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Interpersonal Relationships in Psychiatric Nursing

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INTERPERSONAL RELATIONSHIPS IN PSYCHIATRIC NURSING

A Thesis

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by

Elda Hoke Jenkins

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THE PROBLEM AND THE SETTING

The patients and the nursing personnel are associating in a face-to-face relationship on the Head Nurse Unit of the psychiatric hospital. Would a sociological study of interactions among the nursing personnel, among the patients, and between the two reveal elements essential for the dynamic direction of psychiatric nursing? Because such a study would involve an area of human relationships which is of a broader social contact range than the nurse-patient relationship, the exposure of the elements possibly involved in the broader situation may have implications for psychiatric nursing education.

An investigation of the problem will require progression through the following steps: an examination of the interactions originated by the nursing personnel to the nursing personnel, by the nursing personnel to the patients, by the patients to the nursing personnel, and by the patients to the patients to discover elements residing in the situation; an examination of the present psychiatric nursing educational program to ascertain which of these elements are included and what, if any, gaps are present; making recommendations for the closing of the gaps, should such be present, to provide for the dynamic direction of psychiatric nursing.

The setting of the study was on one Head Nurse Unit, classified as an acute service for women, within a psychopathic hospital. In application of the sociometric observation technique of R. W. Hyde and R. H. York, twenty-three sociometric observations were made over a period of three weeks providing a random sampling of life on the nursing unit from mid-morning to

early evening. Although other persons, such as doctors, occupational therapists, and psychologists, enter into the interpersonal relationships on the unit, no attempt was made to study the interactions other than those among the nursing personnel, among the patients, and between the two because only factors of most immediate concern to the solution of the problem were considered. Further exploration was limited to surveying the psychiatric nursing educational course, offered by affiliation for students of nursing in a basic program, in operation at the hospital where the study was made. Directed observations, interviews, participation in staff conferences and group activities supplemented the sociometric and survey methods.

A review of the literature and point of view of the investigator will be presented in order to introduce the reader to the related factors which have led to such a study. The results of the interaction study will be presented as well as the interpretations from the analysis of the educational program. Should gaps appear, recommendations will be made as to how they may be closed through improving the direction of the psychiatric nursing education course.

SURVEY OF THE LITERATURE: CONCEPTUAL SCHEMA OF THE INVESTIGATOR

Interactions among nursing personnel, among patients, and between the two are within the broad area of interpersonal relationships. To what extent has this area been considered in general education, in the social sciences, in health promotion and preventive psychiatry, and in nursing education as related to psychiatric nursing? Have studies similar to this one been made, and, if so, what are the duplications between them and the present study? What relationship will the investigator's point of view have to the study? These are questions which will be considered in this chapter.

I. SURVEY OF THE LITERATURE

A common concern in interpersonal relationships. There is an ever increasing recognition of the need for research in human relationships. The accentuation of the concern stems from the rapid advancement of scientific inventions and technology in military warfare which cumulated in the release of the atomic bomb. The report of the President's Commission on Higher Education[1] has stressed the development of social invention and social technology so that advancements may be made in our social relationships whether it be at the "grass roots" level or at the level of international affairs. The report of the National Conference on Higher Education[2] referred to obligations at all levels of education in improving interpersonal relationships.

The Social Science Research Council[3] representing seven national scientific societies--anthropology, economics, history, political science, psychology, sociology, and statistics--as well as the Society for the Psychological Study of Social Issues[4] have pursued constant research in this area. Two contemporary journals, American Journal of Orthopsychiatry[5] and Sociometry,[6] are outstanding in their contributions in research and applied social technology in the field of interpersonal relationships; the Journal of Abnormal and Social Psychology[7] increasingly is developing its content in this direction.

Methods used in the social sciences have been given considerable attention. Questionnaires, attitude tests, sociometric scales as well as the diagrammatic methods such as the cartograph have been described by George Lundberg[8] as valuable analytical and expository tools in studying interpersonal relations.[9] The sociological indices used by Kurt Lewin, Ronald Lippitt,[10] and Jacob L. Moreno[11] have made it possible to make scientific generalizations concerning interpersonal relations. Through the sociometric tests, it is possible to study scientifically group formations and atmosphere, leadership, isolate, and follower patterns. Helen Jennings[12] presented a detailed study of personality in the social situation; this study is exemplary of the high degree of scientific accuracy that can be achieved in utilizing sociometric methods in studying the emotional contact range of the individual.

The transcontinental World Federation of Mental Health,[13] as well as the National Committee for Mental Hygiene[14] are mutually concerned with common areas of research in human relationships and the implementation of more wholesome relationships amongst all people. The passage of the National

Mental Health Act[15] is indicative of changing cultural attitudes towards the problem.

In the field of psychiatry, new perspectives have developed as a result of the war; these trends have been vividly portrayed and clarified in Psychiatry in a Troubled World.[16] Among the major groups of research issues confronting this specialty are the social complexities.[17] The extension of group therapy[18] is indicative of the social awareness in modern preventive psychiatry. Despite the advances made in psychiatry, the psychiatric hospitals have tended to lag behind the current trends in treatment.[19] One survey[20] has revealed a lack of understanding of the functions of the psychiatric nurse. At the present time the Group for the Advancement of Psychiatry[21] is studying the role of the psychiatric nurse.

The National League of Nursing Education[22] has long been concerned with the problem of interpersonal relations in constructing curricula on both the basic and advanced levels in psychiatric nursing. Helena Willis Render's recent contribution to the field, Nurse-Patient Relationships in Psychiatry,[23] presents a dynamic approach to psychiatric nursing, marking a sharp cleavage with the traditional pattern of custodial care. Therein, she makes frequent references to the "ward atmosphere."[24] In earlier publications, Katherine McLean Steele[25] and Madelene E. Ingram[26] respectively had discussed manipulation of the immediate environment and management of the ward group. A survey of the psychiatric nursing articles in the American Journal of Nursing indicates concern primarily with integration of psychiatric nursing in the basic curriculum,[27] psychiatric nursing education and existing needs,[28] nursing care studies,[29] and specific nursing problems such as special therapies, restraint, and seclusion.[30] Other articles per-

tain to group dynamics in psychiatric nursing.[31]

In view of the foregoing it does not seem surprising that Esther Lucile Brown[32] in her report on nursing in the United States stressed the needs of nurses for analyzing aspects of and developing skill in interpersonal relations. This skill appears to be applied, as specifically indicated in A Thousand Think Together,[33] primarily to nurse-patient relationships, nurse relationships in the health care team, nurse-doctor relationships, and nurse-public relationships. The concern here seems to involve intergroup relations between nursing groups and other groups; however, Mary Ella Chayer[34] has indicated that intragroup relations in nursing are also of immediate concern. Genevieve K. Bixler[35] has said:

> ....In the administrative relationships and functions of the entire hierarchy concerned with nursing in the hospital, the director of nursing, the hospital administrator, supervisors, head nurses, attendants, and orderlies, there is another large area for research.

A brief survey of the literature has indicated the need for research in the social sciences and the increased recognition of the importance of interpersonal relationships. Professional groups are turning their attention and integrated study towards an overall appraisal of human welfare as evidenced by the increased number of publications that have been either a joint product of or separately sponsored by various professional persons studying a common problem--how the individual lives. A survey of the nursing literature has shown that it contains little specifically related to interactions among the nursing personnel, among the patients, and between the two. It appears that increased structuring of interpersonal relations in psychiatric nursing may enrich the psychiatric nursing curricu-

lum. In all fields of endeavor there are implications for the need of such a study of interactions. In the following survey of other literature indications will be presented that the problem is being considered in varied sections of psychiatry today. It will be shown in what way these studies differ from or are similar to the present one.

A consideration of other studies related to the present study. Most of the studies on the interaction patterns in the psychiatric unit have dealt with problems of group therapy with children or they have been approached from a sociological frame of reference with little specific application to nursing. Studies on the therapeutic role of the nursing personnel and their interrelations with others in the group had been reported prior to 1940.

One of the original studies in utilizing the employees as therapeutic agents was made at the Worcester State and King's Park State Hospitals by Cody L. Marsh.[36] Although these studies may appear to be comparatively simple in light of more recent studies in group dynamics, the work at those two hospitals has proven to be basically sound, and the reports form part of the classical literature on psychiatric care. William Bryan,[37] who for years pioneered in psychiatric hospital administration, predicted the evolution of the role of the psychiatric nurse to one of counselor of the social ward group. A study by Lauretta Bender[38] portrayed the role of the nurse as a therapeutic agent. She described and analyzed scapegoat formation on the ward, the therapeutic effect of the ward routine based on the natural rhythm of the child, and the part the nurse played in developing feminine interests in girls and in participating in spontaneous group discussions. One of the more systematized of the earlier studies was made by

Howard Rowland[39] who studied friendship patterns and interaction processes in two state hospitals. These sociological studies presented realistically the social organization of the hospital communities; even in the hierarchy of the authoritarianism, described by Rowland, one is impressed by the therapeutic role the nurse, quite unknowingly, was playing.

Since 1940, there has been an increasing number of reports on the significance of the social group, including both patients and personnel, as part of the therapeutic process. Ben Rubenstein[40] pointed out psychological limitations in the hospital situation, emphasizing the favorable effects produced in the group of patients by a leader who is permissive, who gives unconditional acceptance, and who allows free verbal expression of pent-up feelings. Bruno Bettelheim[41] reported a program for carrying out hospital routines within meaningful interpersonal relations and how the group, either through the presence of or absence of positive action, influences the individual. A. S. Szurek[42] has described a method of group therapy which meets the needs of the personnel handling problems of the group. It was found that group discussions, although they did not change the more or less unalterable personality traits of the individual nurses, provided the nurses with an opportunity to ventilate their difficulties arising from their interactions with patients and offered a greater prospect that the patient's problems, symptoms, or impulses would be met with a uniformity of attitudes from all the staff. As a result of these group discussions, the nurses were able to establish more wholesome nurse-patient relationships which brought greater security and a more rapid change in the attitudes of the patient. Kathleen Stewart[43] has discussed problems the nurses have faced in meeting behavior patterns related to deeper central anxieties

being mobilized rapidly in the group.

The utilization of the nurse as a group therapist is sharply portrayed in two articles based on the work of the Illinois Neuropsychiatric Institute, Children's Ward.[44] These articles make an interesting study of group dynamics in a democratic as contrasted with an autocratic nursing situation. One report from the Eloise Hospital and Infirmary, Michigan,[45] described the nursing personnel as adjunct therapists in group therapy. This is one of the few studies where a control ward was used in validating the method of therapy. Realization of the therapeutic potentialities of the ward group situation was studied by R. L. Jenkins.[46] Lewis Wolberg[47] has stressed the therapeutic importance of the group through interactions of patients with one another and their experiences in relationship with the ward personnel. This has been further clarified by G. Schauer[48] in his sociometric study. More specific application of this concept has been made to the care of the schizophrenic patient.[49] The research work in interpersonal relations at the Boston Psychopathic Hospital[50] has been reported in the literature. This work originally started with the development of a technique for studying interpersonal relations; as the studies progressed the techniques were found applicable to various areas associated with the care of the psychiatric patient.

In the studies reviewed, conventional clinical methods such as interview of patients and employees, description of progress of patients, case presentations, nursing care studies were utilized. It seems evident that many of these reports were based on group discussions, staff conferences, personnel conferences, etc. Various types of sociometric techniques were utilized in some of the studies. There will be more similarity between

this study and those made by Howard Rowland and Robert Hyde. It is similar to the former in its consideration of interactions and to the latter in its utilization of the same type of sociometric technique, the modified sociogram, and the same field resources. It differs from both studies in the nature of the sampling and limitations to the Head Nurse Unit.

The preceding reports have indicated the nursing personnel as agents in the social process; thus can be seen the importance of making a detailed study of interactions among the nursing personnel, among the patients, and between the two. This sociometric study of selected interactions in a psychiatric hospital will be a limited one using social technology in the field of interpersonal relations in psychiatric nursing. It is believed that a systematized method of studying the group will provide the psychiatric nurse a framework in which she can more adequately analyze problems which previously have caused her difficulty when equipped only with the individual patient approach. Individual approach has an important place that no other method can fill, particularly as it is broadly interpreted to mean a plan of care constructed to meet the total nursing needs of the individual who interacts with others of his community; however, the psychiatric nurse is more frequently confronted with the problem of simultaneously nursing to a group of patients which requires a different type of skill. It is not so much a question of individual vs. group methods as an understanding that each method represents a different level of development with varying projected goals.

II. CONCEPTUAL SCHEMA OF THE INVESTIGATOR

Understanding of this study may be facilitated through orientation to the philosophy or point of view from which it stems. The following are those values and concepts in psychiatric nursing that the investigator holds to be good and worthy of pursuit.

The contemporary concept of psychiatric nursing is slowly but progressively changing; the nurse's concern over the emotional aspects in health and disease is becoming a part of all nursing. What is talked about as "psychiatric nursing" today will be so closely integrated and interwoven in all nursing that the present concept will no longer be functional. There will evolve a true specialty in psychiatric nursing--a specialty that will have its point of focus in the psychiatric hospital, in the mental hygiene clinic, and other community agencies where people with emotional problems are receiving special treatment so that they may share equitably in rights, privileges, and satisfactions that life in common affords. The psychiatric nursing specialist will then be a co-worker in social planning to minimize conflicts and magnify social order for the common good; a co-worker in the therapeutic team whose focus of interest is the treatment of the psychiatric patient, the promotion of mental health; a co-worker in the educational program of the community. In the meantime while this process is evolving, the psychiatric nurse may have to work in partial darkness, refining the techniques and concepts that she has at the present time, but forever reaching out into the future and drawing knowledge and understanding from allied fields to fit within her own conceptual framework.

A community may be thought of as an agglutination of groups that inter-

act. The concept of the hospital as a community is portrayed in the psychiatric hospital for within it are groups of people who are "living together" within a specific organization governed by common mores and sharing common causes and interests. As soon as the psychiatric patient has entered the hospital--and in some situations even before--he has entered into a therapeutic relationship which will broaden out into a social relationship as he progresses toward better mental health. The Head Nurse Units are the units of social action which comprise part of the hospital. The Head Nurse Unit, thought of as a "nursing community," has an entirely different connotation than the term "ward" which is highly reminiscent of Bedlam and days of detention of the mentally ill. The nursing community more closely approximates the family unit psychologically in structure with father-mother-sibling formation taking the form of the personnel-patient, patient-patient formations. The rest of the hospital with its "community facilities" such as the services of the dentist, the theater, the dance, the church, etc., more closely approximates the neighborhood in which the family unit is located.

As soon as one begins to think of the nursing unit as a "community," the nature of the problems of psychiatric nursing may be more easily interpreted from sociological and psychological aspects. Problems of integration, reintegration, and separation instead of admission, transfer, and discharge may now be discussed. The patients and personnel within the community become members of the same group. The socialization processes that are inherent in a group are therapeutic and so the patient benefits in proportion to the socialization processes. At times, they are individuals in a group--at other times, they are a part of the group. Experiencing

these living situations together becomes a therapeutic process. Instead of problems centering on somatic aspects, they will now be concentrated into areas less clearly defined wherein relationships are being formed and dissolved. The"therapeutic process" may be thought of as the psychological consequence of the interactions. How the nurse in such a setting feels toward the patient and her co-workers is as much a concern in psychiatric nursing as how the patient may feel toward the nurse and his peers.

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A STUDY OF INTERPERSONAL RELATIONS IN THE PSYCHIATRIC NURSING COMMUNITY

A study of the nursing community may lead to understanding relationships significant to the entire community as well as to individuals. Social science methods of study present complex aspects of a situation as a whole, specific parts of which are further analyzed. One such method, the sociometric observation technique or sociogram, may be used by the nurse to investigate relationships of the persons within her community. The method, as used in this study, will be described, demonstrated, and applied in analyzing interactions occurring within the natural setting of the psychiatric nursing community.

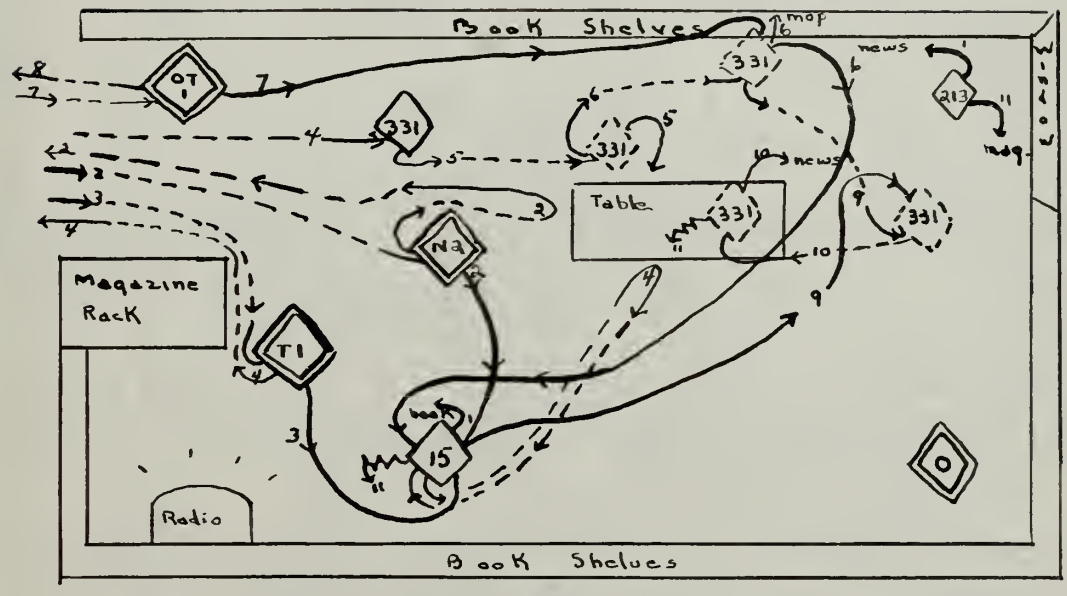
I. THE SOCIOGRAM

Description of the sociogram. The sociogram[1] is a graphic representation which visualizes the underlying structure of a group in the nursing community and the position each individual has within it during a fifteen minute interval. Patients and personnel are pictured by diamonds which are presented within spatial relationships to one another and to the gross physical surroundings. Single-lined diamonds represent patients; double-lined diamonds represent personnel. Each side of each diamond has a specific and constant meaning: the left hand upper side means no activity; the left hand lower side means motor activity; the right hand upper side means attention; and the right hand lower side means verbal activity (see the identification of the diamond in the key in Figure 1). Interactions are

1. See reference 50, page 20.

FIGURE 1
SAMPLE OF A SOCIOGRAM

Date: June 19, 1948
Place: O.T. Library
Time: 10:10-10:25 a.m.
Setting: Activities have been started in various sections in O.T.



Key

15.	Theresa Brown	N2.	B. Peese	none	attention
213.	Betty Wise	T1.	J. Elwood		
331.	Patrick Green	O.	E. Jenkins		
OT1.	G. Bloom			motor	verbal

1. Radio playing soft music. 15 sitting by radio, reading book. 213 sitting by window reading newspaper.
2. N2 enters, to 15, "Hello there." 15 looks up. N2 puts magazines in stack on table, goes out.
3. T1 enters, originates to 15 who verbally responds.
4. T1 exits; 331 enters. 15 puts book on table, gets magazine.
5. 331 picks up magazine, glances through it.
6. 331 with hands in pockets looks at bookshelf, regards map, looks at 15.
7. OT1 enters, to 331, "How about a checker game—you interested?" 331 shakes head "no."
8. OT1 exits.
9. 331 wanders. 15 regards him.
10. 331 sits on table and looks at Boston American newspaper.
11. Polka on radio; 15 and 331 tapping feet to music, continuing to read. 213 concentrating on Your Life.

depicted as follows: broken lines denote motor interactions; unbroken lines denote verbal, attention, and no interactions. The direction of the interactions is shown by arrows stemming from the diamonds. The graphic representation is accompanied by a key which identifies the diamonds and a recording of all the units of action, i. e., those interactions which occurred simultaneously and in relation to one another.

Figure 1 illustrates a sociogram wherein is visualized the socialization process in the patient's library showing that the three patients, 331, 15, and 213, are not interacting with one another except when 331 looks at 15 who gives no response (see line 6 stemming from 331's attention side to 15's no response side) and later when 15 pays attention to 331 (see line 9 stemming from 15's attention side to 331's no response side). Socialization is increased by the introduction of the personnel, N2, OT1, and T1, but at no time is 213 distracted from her reading. Through utilizing the recording of the units of action the sociogram may be read; for instance, unit of action number two is read as follows: the dotted line number two with the arrow pointing toward N2 indicates that she is entering; the unbroken line number two stemming from her verbal side to 15's attention side indicates 15 paying attention when N2 greets her; the second unbroken line number two with arrow pointing away from N2 portrays her putting the magazines on the table and leaving the room.

Process of making a sociometric observation. The process of making a sociometric observation consists of five areas: structuring, recording, terminating, following-up, and interpreting the observations. The objective and subjective aspects of the process will be considered in relation to progression from area to area.

a. Structuring

Structuring the observation is the first area in making a sociogram. The observer lays the foundation for the period of observation having selected a section where the patients have congregated in the natural setting of the community.

In any community, there is usually found some focus of interest, such as the local drug store in a rural community, where people gather to talk over happenings of the day. The location of the common meeting place may change in the natural course of events in the nursing community from the lounge to the dining hall or other place. The study of group interactions involves the introduction of a control which must not alter the natural setting where there are infinite variables. It has been found that one or more patients who present outstanding nursing problems generally provide adequate control with any group, and these may be identified through conferences with the Head Nurse. This type of control was used in the present study although in other studies the nature of the control would be presumably altered to meet the needs. A sociometric study made under the foregoing circumstances will involve nursing personnel in relationship to one another and to the patients. This is a natural method of observing their social relationships as well as the relationships of the patients to each other and to the nursing personnel.

The introduction of the sociometric observer into the nursing community may be accepted by both patients and personnel according to previous conditioning. When the sociometric observer, unlike previous observers, is a nurse in uniform, a re-orientation process is initiated. The patients are generally accustomed to a participating nurse and may view with suspicion

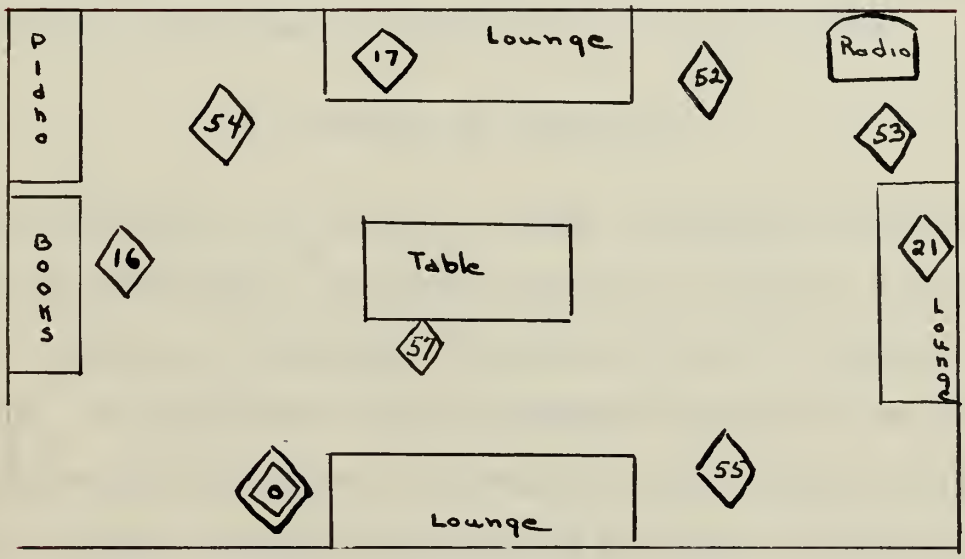
or curiosity a nonparticipating nurse-observer. Nursing personnel may regard differently the nurse-observer from the doctor, psychologist, or student-observers. The nurse as a neutral observer is in a role which is not generally acknowledged, and its acceptance is not readily made. Thus it becomes apparent that structuring involves having the personnel within the community understand what the nurse-observer is doing and enlisting their participation. As time passes the nursing personnel tend to become reoriented to having the nurse-observer in the nursing community, and the patients in turn begin to accept her in this new role.

The nurse-observer enters unobtrusively the natural setting of the group and proceeds to set the stage for the period of observation. "Setting the stage" not only lays the foundation for the mechanics of constructing the sociogram but provides opportunity for the nurse to assume a neutral role and for the patients and personnel to become acclimated to the restructuring of the group caused by her presence. Locating herself somewhat removed from the core of the group, she proceeds through the mechanics of the structuring process which involves portraying spatial relationships of the physical surroundings and the persons occupying it; identifying patients and personnel; describing what has directly preceded; and noting the date, the nursing community, and relation of the group within it. As soon as attention has centered away from the observer, she begins the observation, adding to the information the time the recording began.

Figure 2 illustrates the graphic portrayal completed during an area of structuring. The spatial relationships, although only approximate, reflect immediately many factors about this nursing community: there is opportunity for the patients to use freely diversional activities provided, such as the

FIGURE 2
SAMPLE OF THE GRAPHIC PORTRAYAL OF STRUCTURING
IN THE PROCESS OF MAKING A
SOCIOMETRIC OBSERVATION

Date: June 1, 1948
Place: Nursing Unit #3, Lounge
Time: 2:00-2:15 p.m.
Setting: Other patients on way to O.T.



Key

21.	Sarah Bates	54.	Unidentified	none	attention
52.	Helen Bartlett	16.	Louise Hobbs		
58.	Unidentified	55.	Unidentified		
7.	Louise Brown	17.	Dorothy Black		
		0.	E. Jenkins	motor	verbal

piano, books, and the table radio; the furniture is arranged so that small groups may form thus encouraging release of the natural spontaneity of the groups; the room itself is small in comparison to some of the large "day-rooms" found in the custodial type of psychiatric institution; there is opportunity for free flow of traffic between this room and the hall through the open door to the left; the fact that the patients are in the room by themselves, without the presence of an employee, has dynamic implications of far-reaching importance for it represents a deviation from the traditional "observation precautions" concerning the acutely ill patient.

b. Recording the Observations

The second area in the process of making a sociometric observation is recording the observations. When observations are related to a research project, a careful and standardized recording of data is of greatest immediate need. The standardized unit of measurement employed in the sociometric observational technique is the "unit of action" which is defined as a series of actions occurring simultaneously and usually related to one another. Proceeding with Sociogram #1, the observer records the units of action and numbers them according to sequence:

1. 21 & 52 verbalizing very rapidly; 52 accusing 21 of being "untidy," "disgraceful," "repulsive," "shameful," 21 defending herself verbally, "So what--I'm not as bad as you...." 53 reading. 54 glancing at 21 & 52. 7 working on puzzle. 16 reading magazine. 55 shows no response.
2. S1 enters, moves further into room with hands on hips, speaks to 21 & 52, "What's going on here?" 21 & 52 pay attention. 55 looks at S1. 52 continues reading. 7 looks at S1. (At this point, S1 would be inserted into the graphic form and her number and name added to the key.)
3. S1 sweeps out of the room, hands on hips. 55 follows S1 out. 21 & 52 resume verbal abuse.
4. S1 returns, walks directly towards 21 & 52, places hands on

hips, looks at 21 & 52 who stopped verbalizations as soon as S1 approached, now looking at her. 53 looking.

5. S1 says, "Will one of you go into the other room; we can't have this here!" (forcefully). 21 & 52 pay attention. 16 & 54 pay attention.
6. 21 to S1, "Why do I have to be here?" S1 to 21, "Because the doctor feels ...." (suspended). 21 to S1, "But do I have to be here!" S1 gives no response.
7. S1 walks hurriedly out of the room.

The observer's neutral role, her avoidance of eye-contact with the patients and personnel, as well as her skill in devising a shorthand technique greatly facilitates the recording. As new patients or personnel enter the field of observation, the observer portrays their positions in the graph and identifies them in the key as explained in the note accompanying the second unit of action in Sociogram #1. Should the observer continue her observations of the same field after the close of the first fifteen minute interval, she notes the time the first sociogram ended and the time the second one begins. In this way each sociometric observation is kept within a standard unit of time.

Interobserver reliability is ascertained subsequent to achievement in observing and recording through cooperation with another person who is skilled in the sociometric observational technique. The two observers, entering the natural setting so that they have approximately the same perspective of the field, synchronize watches, check symbols for the graph, begin and end observations at identical times. The reliability is based on the consistency between the two observers within the common range of observable material. Knowing that fatigue increases in proportion to the length of time spent in sociogramming and the complexity of the field of observation, the discerning observer may plan her periods of observation so

that fatigue does not decrease the reliability of her recordings; likewise through competent manipulation of interactions originated to the observer, she is able to circumvent other aspects from affecting reliability. One of the aspects concerns another sociometric observer chiding the observer-recorder; in time a spontaneous reciprocal interaction leads to new perceptions with both observers developing more understanding of one another. When the observer remains in a neutral role, accurate recordings may be continued even in the face of considerable verbal attack from the patients. When patients originate to the observer, the content of originations for the most part usually fall into one of several categories, i.e.; "What are you doing?"; "Are you going to show that to the doctor?"; "So you think you're going to get something on me....." It is not surprising, on the other hand, to have patients inquire, once they have become familiar with the observer and have accepted her as part of the group, "How are you coming with your sociograms, Nurse?" Originations from the patients may usually be manipulated through the neutral role of the observer; through simple, honest answers when indicated; through indirection; and occasionally through placing limitations on the originator. Many difficulties in keeping the observations and recordings accurate and reliable may be encountered by the new nurse-observer, especially problems involving non-participation, avoidance of eye-contact, fatigue, and originations from patients and personnel.

c. Terminating the Observations

Following the period of recording, the process of making a sociometric observation leads on to the third area, terminating the observations, which is analogous to a separation experience. The observer leaves the group as

unobtrusively as she structured and recorded thus maintaining her neutral, non-participating role throughout the period of sociogramming. The simple process of leaving the field of observation terminates the observation. The separation experience inherent therein facilitates role change from non-participating to participating nurse when she reenters the previous field of observation.

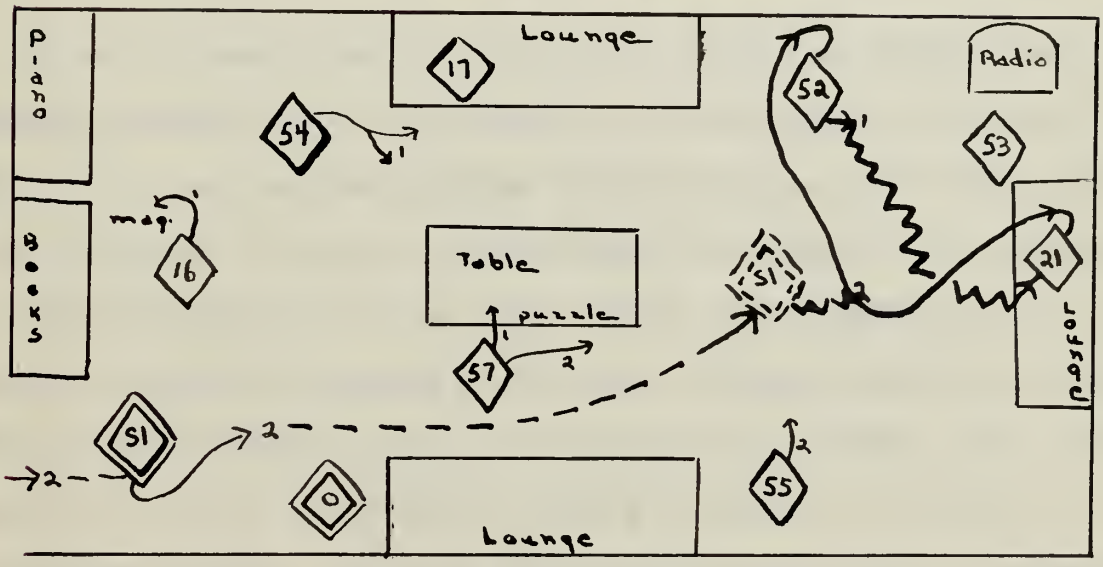
d. Following-up the Observations

Following-up the observation is the fourth area in the sociometric process. The units of action are transcribed graphically onto the floor-plan so that their numerical sequence is retained. Greater accuracy and reliability tends to be achieved if the transcription is made immediately following the observations. Significant interactions or events occurring immediately after the period of observation are recorded following the last unit of action in such a way to indicate that the events did not occur within the fifteen minute interval. The graphic portrayal of the units of action helps to clarify the observations and to analyze the nature of the data observed. The legibility of the sociogram may be hindered by the portrayal of too many units of action. This may necessitate drawing two or more sections of the sociogram for clear, visual presentation.

Figure 3 may be used to illustrate the insertion of the first two units of action from Sociogram #1 onto the corresponding graphic presentation. Therein all lines numbered with the figure one belong to the first unit of action, and all lines numbered with a two may be identified with the second unit of action. The interactions between 52 and 21 and between S1, 52, and 21 are zig-zagged to indicate the intensity of the interaction.

FIGURE 3
SAMPLE OF GRAPHIC PORTRAYAL OF UNITS OF ACTION
IN THE PROCESS OF MAKING A
SOCIOMETRIC OBSERVATION

Date: June 1, 1948
Place: Nursing Unit #3, Lounge
Time: 2:00-2:15 p.m.
Setting: Other patients going to O.T.



Key

21.	Sarah Bates	16.	Louise Hobbs	none	attention
52.	Helen Bartlett	55.	Unidentified		
53.	Unidentified	17.	Dorothy Black		
57.	Louise Brown	0.	E. Jenkins		
54.	Unidentified	S1.	R. Bailey	motor	verbal

1. 21 & 52 verbalizing rapidly; 52 accusing 21 of being "untidy," "disgraceful," "repulsive," "shameful." 21 defending herself, "So what— I'm not as bad as you....." 53 reading. 54 glancing at 21 & 52. 7 working on puzzle. 16 reading. 55 no response.

2. S6 enters room, moves further in with hands on hips, speaks to 21 & 52, "What's going on here!" 21 & 52 pay attention. 55 looks at S6. 53 continues reading. 7 looks at S6.

Although the quarrel between 52 and 21 had attracted the attention of only one patient, 54, the autocratic approach of the student brought attention from two patients, 55 and 57, and caused arrest of the quarrel between 52 and 21 who paid attention to the student. Transcriptions of units of action three through seven would be portrayed according to similar techniques.

e. Interpreting the Observations

Having proceeded from the first area of structuring through areas of recording, terminating, and following-up the observations, the observer arrives at the last area, interpreting the observations, which brings meaning to the sociogram. The type of interpretation will depend upon the purposes for which the sociogram has been made; however, understanding the total configuration enhances the meaning of its parts. Whereas sociograms may be related to one comprehensive area of research such as lobotomy, other sociograms may be related to psychiatric nursing viewed from sociological or psychological aspects. The nurse may enlist the consultation of others in the clinical team to interpret the sociogram; or as clarification is generated through her own experiences in the nursing community related interpretations may evolve.

II. SOCIOMETRIC STUDY OF INTERACTIONS AMONG THE NURSING PERSONNEL, AMONG THE PATIENTS, AND BETWEEN THE TWO

Collecting the data. Limitations of the study of interactions among the nursing personnel, among the patients, and between the two have been stated in Chapter 1. Preparation for the study consisted of planned and spontaneous conferences and interviews with professional and non-professional workers in the clinical team, observations of activities within the hos-

pital community, and pre-survey of the nursing communities.

Records comprised a daily roster which facilitated identification of patients and personnel, daily notes of the observer's progress, a file of the nursing problems which assisted in checking the control used. Following the interpretation of each sociogram according to the total relationships involved, the patients and personnel were checked on another record which tabulated the number of times each person appeared throughout the study and in which sociograms she had been observed. Within the twenty-three sociograms there was a total of sixty-two patients and eighteen nursing personnel, averaging five sociograms per patient and four per personnel. Of the nursing personnel involved there were two graduate nurses, eight student nurses, seven psychiatric aides, and one volunteer nurse!s aide. Inter-observer reliability in this study was 92 per cent which indicated reliability extensive enough to be worthy of classification and further study of the data.

Classification and organization of the data. An adequate system of classifying the numerous, apparently subjective activities of the social groups observed would separate the masses on the basis of their likenesses and differences. The unit of interaction appeared to be the most practical unit of measurement for classifying the data. Interaction connotes mutual or reciprocal action within the social contact range of individuals in a group; it is primarily a one-to-one relationship. The term in this study implies that one person originates or responds to another (closed interaction) or that one person originates or responds to two or more persons (open-end interaction). The interactions that involved other than those persons to whom the study was limited were not classified. The classification system

devised for this study was a sociometric scale (see Table 1) which was compiled through conferences with members of the clinical team and a modification of the Robert York Sociometric Scale.[2] The sociometric scale, as devised, has a three-prong approach: the nature of the problem presented the first classification, interactions according to origination, i.e., nurses to nurses, nurses to patients, patients to nurses, and patients to patients; the organization of the nursing community activities presented the second classification, interactions according to type, i.e., administrative and non-administrative; the socialization process inherent in the nursing community provided the third classification, interactions according to quality, i.e., aggressive, authoritarian, neutral, friendly, and socialized.

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2. From Harvard School Social Relations, unpublished.

TABLE I
CLASSIFICATION OF INTERACTIONS

According to Origination	Description
1. N--N:	Nursing personnel (graduate nurses, student nurses, psychiatric aides, and volunteer nurse's aides) initiated interaction to other nursing personnel.
2. N--P:	Nursing personnel initiated the interaction to patients.
3. P--N:	Patients initiated the interaction to nurses.
4. P--P:	Patients initiated the interaction to other patients.

According to Type	Description
1. Administrative:	Those interactions which pertain to routine nursing duties wherein custom or policy fairly well regulates the behavior, i.e.; keeping appointments; caring for property; carrying out suicidal observations; preventing accidents; giving or receiving medications and treatments; housekeeping; preparing meals and baths; placing a patient in seclusion or restraint or being placed in either; questioning prognosis or treatment, etc.
2. Non-Administrative:	Those interactions wherein the person initiating the interaction is free to act spontaneously, i.e.; playing games, engaging in social conversation, initiating group or solitary activities, playing the radio or piano, etc.

According to Quality	Description
1. Aggressive:	Closed interaction: shows autonomy through negativism, resistance, rebellion; shows jealousy, envy, tries to take something from others; makes aggressive joke (sarcasm), blames others; shows irritation, dissatisfaction; degrades self or others; moralizes, threatens others physically or verbally; defends self physically or verbally; pushes, shoves, kicks, slams; vents hostility directly or indirectly; crying, picking, pacing.

TABLE I, CONTINUED

According to Quality Continued	Description
2. Authoritarian:	Closed interaction: gives bald command or direction, implying no autonomy for others; denies permission, blocks, restrains, prohibits; gives reproof, criticism, reminds another of his duty; demands amends; attempts to interrupt or take over, dominate; asks that something be done without explanation; suspends permission or explanation; clangs keys, threatens habeus-corpus or reporting to authority; restraining as in restraint or seclusion procedure.
3. Neutral:	Closed interaction: gives casual or active attention to people or activity; enters or leaves the group without comment; pays no attention to origination; uses reserve, indifference, passivity; asks factual questions or gives factual answers; shrugs shoulders; nods head.
4. Friendly:	Closed interaction: shows familiarity, uses nickname, first name, "we" in the sense of "you and I"; offers to help, give out resources, share, exchange with another; sides with, praises, commends another; offers to assume a task or duty on behalf of another; shows courtesy, intimacy, sympathy, confidence; uses jokes and laughter and smiles constructively for another's enjoyment; assigns tasks, gives or imputes a role to others; instructs about task, telling or showing where, when, how, why; suggests an activity implying autonomy for others; encourages, reinforces, redirects, permits other's on going acts;comes to the social rescue of another; looks out after another, shows personal interest; carries on social discourse with another.
5. Socialized:	Open-end interaction: shows identification with a group; brings in a third person into the activity; friendly conversations involving more than two persons; redirects, encourages, reinforces, permits a group's activity; uses jokes, laughter, smiles constructively for a group.

The sociometric scale was utilized in organizing the raw data: each unit of action within a sociogram comprised several interactions which were tabulated and classified according to origination, type, and quality (see Figure 4 in Appendix); these in turn were transferred to the Master Classification Sheet (see Table 2 in Appendix) which reflected the number of interactions in each sociogram according to the classification system as well as the total number of interactions.

The entire series of sociograms were checked for the reliability of the classification system through the cooperation of another psychiatric nurse whose educational background and professional experience compared favorably with the investigator but who was not skilled in the sociometric observation technique. He had received a brief explanation of the sociometric technique and instruction in how to classify the interactions. Interactions classified according to origination had a 93 per cent reliability. There was some difficulty in consistently classifying when there was a mixed group of personnel and patients, particularly when there was a high rate of interaction. Interactions classified according to type had an 88 per cent reliability. The error was largely in the interactions originated by patients. During the period given to the study, there was but a limited amount of time which could be devoted to conferences to establish the definitive descriptions of administrative and non-administrative activities so that a higher degree of agreement on classification might be reached. This, no doubt, accounts in part for the higher percentage of error in classification, particularly when a diversified group of personnel was involved. The interactions classified according to quality had a reliability of 72 per cent. A large amount of this error was attributed to confusion

of friendly with socialized quality; confusion of one extreme (aggressive and authoritarian) with the other extreme (friendly and socialized) comprised only 15 per cent of total error in quality. The neutral quality occasionally was confused with the authoritarian and friendly qualities and this error was concerned primarily with classifying areas of attention.

The reliability of the classification system had been further checked through the assistance of a psychiatrist who was skilled in the observation technique. The reliability here was somewhat greater as might be expected in as much as the two workers had been accustomed to correlating research in the clinical situation. Another factor that influenced high reliability rate was that the checking had been done on the series of sociograms that had been used to check inter-observer reliability wherein the psychiatrist had been the second observer. This seems to indicate that greater reliability can be achieved in classifying the data when the workers are skilled in the sociometric observation technique; however there is sufficient evidence that useful information can be secured by a psychiatric nurse who has not been trained in the sociometric technique, although probability of error tends to increase in the area of classification according to type in the situations which involved patients. It is believed, however, that the chance of error will be decreased as the workers can be brought together to discuss and redefine the classification results.

A. OBJECTIVE ANALYSIS OF INTERACTIONS

There follows analysis and interpretation of the data collected. Although patients were all women, the pronoun "he" will be used in reference to them so that they may be clearly differentiated from the nursing person-

nel for whom the pronoun "she" will be used. Likewise, the term "nurse" will be used to designate the collective term "nursing personnel."

The atmosphere within the nursing community. Nursing personnel and patients appeared to be drawn into a situation requiring social interaction on the part of both, as shown in Figure 5A, forming what seemed to be a primary social group wherein there were direct contacts. Sixty-three per cent of the interactions were initiated by patients, indicating the importance of the patients in bringing about dynamic interactions within the group. Further analysis of these interactions showed the patterns of interchange in the social group as illustrated in Figure 5B. Only 20 per cent of the interactions were concerned with administrative roles or modes of behavior previously established. It follows that the social contact range of the group involved primarily spontaneous interactions indicating that interest was focused on interpersonal relations. This in turn appeared to create a warm, friendly, socialized atmosphere as shown in Figure 5C. There was evidence of minimum frustrations as reflected by small percentage authoritarian-aggressive behavior. The neutral interactions perhaps provided a leveling force in the socialization process. With emphasis on interpersonal relations, one may expect that the non-administrative interactions were friendly which is substantiated in Figure 6.

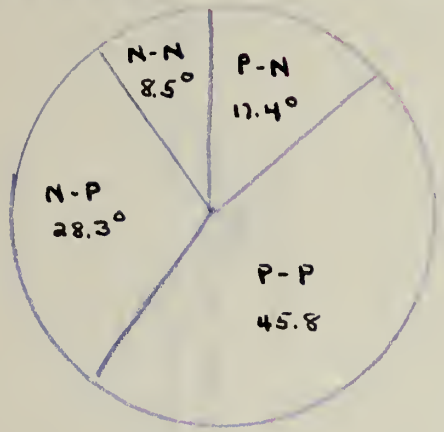
Interpersonal relations among nursing personnel. In the previous paragraph, it was demonstrated that the nursing personnel formed a part of the social group. Their interrelationships may be an important source of influence within the nursing community. Although neutral behavior characterized their interactions, it was balanced by the four other qualities with asocial qualities slightly outweighing the centrifugal behavior (see Table 7

FIGURE 5

ATMOSPHERE WITHIN THE NURSING COMMUNITY

A

Percentage of Interactions Classified According To Origination: Compiled from Table 6A, Appendix.

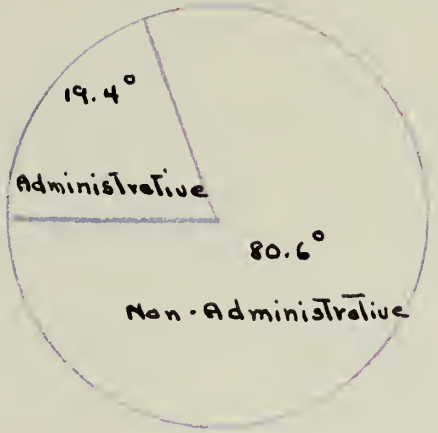


Key

100.0°- 668 interactions
45.8 - 306 interactions
28.3 - 189 interactions
17.4 - 116 interactions
8.5 - 57 interactions

B

Percentage of Interactions Classified According To Type: Compiled from Table 6B, Appendix.



Key

100.0°- 668 interactions
80.6 - 538 interactions
19.4 - 130 interactions

C

Percentage of Interactions Classified According To Quality: Compiled from Table 6C, Appendix.

Key

100.0°- 668 interactions
40.2 - 269 interactions
32.2 - 215 interactions
10.8 - 72 interactions
9.9 - 66 interactions
6.9 - 46 interactions

FIGURE 6

PERCENTAGE ADMINISTRATIVE AND NON-ADMINISTRATIVE INTERACTIONS CLASSIFIED ACCORDING TO QUALITY

Key

5 sqs. - 2 per cent

Administrative Interactions	Non-Administrative Interactions
100.0° - 130 interactions	100.0° - 538 interactions
60.0 - 78 interactions	47.6 - 256 interactions
24.7 - 32 interactions	25.6 - 137 interactions
10.0 - 113 interactions	12.8 - 69 interactions
3.0 - 4 interactions	11.4 - 62 interactions
2.3 - 3 interactions	2.6 - 14 interactions

Source: Compiled from information in Table 5 in Appendix.

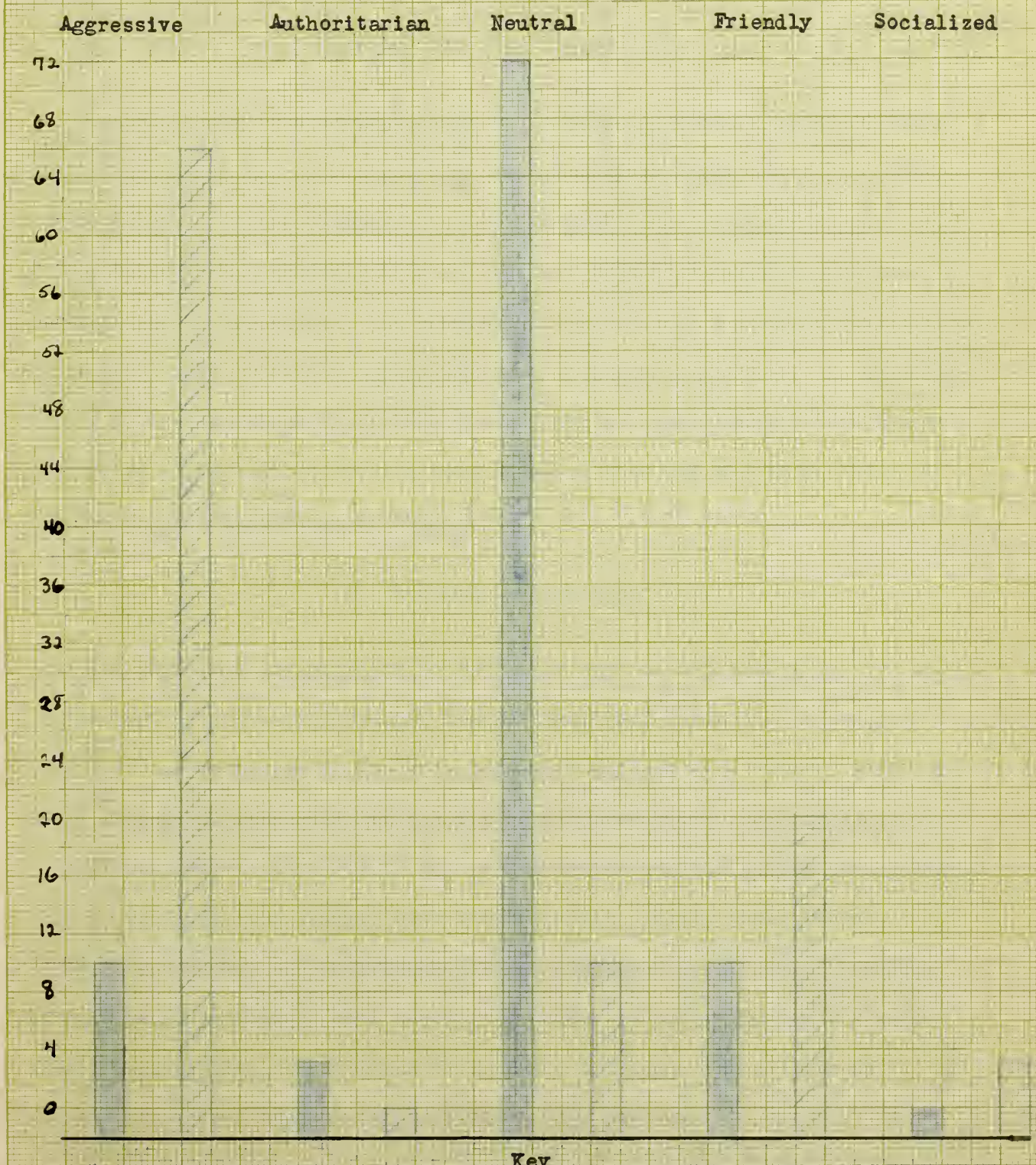
in Appendix). There was a change in behavior depending upon the type of interaction. Neutral quality comprised 74 and authoritarian 15 per cent of all the administrative interactions. Administrative nurse-nurse interactions were seldom aggressive and never socialized. At this point the nature of the nurse non-administrative interactions becomes more apparent. The authoritarian quality was completely absent in this role as well as the neutral quality being reduced considerably. Socialized interactions were increased; however, the friendly and aggressive qualities were most noticeable and equally distributed. In terms of the individual, the nurse originated twice as frequently administratively as non-administratively; she was twice as friendly and six times as aggressive in non-administrative role as in administrative role wherein she was seven times as neutral. Figure 7 illustrates the socialization of each nurse according to her roles.

Nursing personnel relationships perceived as a whole appeared to be fairly harmonious with marked differences occurring in administrative and non-administrative roles. An explanation of this contrast may be that in carrying out administrative functions, the nurse follows a previously established pattern or stereotype. At that time, autonomy resides in her as a group member who, while in that role, remains somewhat detached from the group. At other times, having no pattern to follow, her personality comes into play, either as aggressiveness, negativism, consideration, or "one-ness" with her peers.

Interpersonal relations between nursing personnel and patients. The interplay between nursing personnel and patients comprised 45 per cent of interactions observed. This area, generally considered as the nurse-patient relationship, may be viewed from two facets--the nursing personnel origina-

FIGURE 7

SOCIALIZATION NURSE WITH PEERS
COMPARED ACCORDING TO TYPES



Key

5 sqs. - 2 interactions

Administrative Interaction Non-Administrative Interactions

Source: Compiled from information in Table 7 in Appendix.

ting and patients originating—in order to understand more clearly the interrelatedness.

a. Nursing Personnel Originating

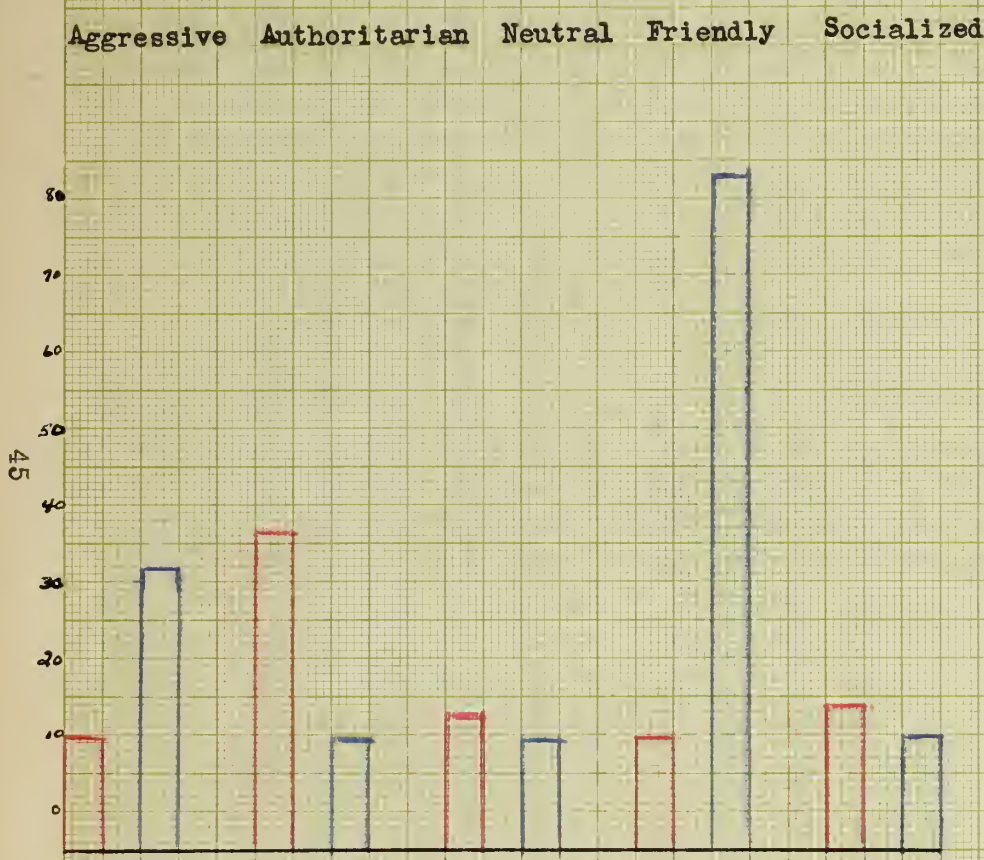
Nurse-patient interactions comprised a large percentage of administrative interactions but only one-fifth of non-administrative ones (see Table 4 in Appendix). Table 8 shows that the nurse-patient interactions were primarily friendly and neutral; this pattern was true in non-administrative nurse-patient interactions, but administrative ones had a lower socialization index reflecting primarily authoritarian and neutral qualities. As shown in Figure 8, the individual nurse was three times as authoritarian in administrative as in non-administrative role at which time she was three times as aggressive and eight times as friendly.

b. Patients Originating

Patient-nurse interactions formed 6 per cent of all administrative and 19 per cent of non-administrative interactions (see Table 4 in Appendix). They were, as reflected in Table 8, primarily friendly and neutral with complete absence of authoritarian quality. This same pattern was repeated in non-administrative interactions but patient-nurse administrative interactions became aggressive and neutral with authoritarian quality still absent. Figure 9 shows that the individual patient displayed more intense behavior in spontaneous relations with nursing personnel at which time he was seven times as aggressive, seven times as neutral, and sixty-seven times as friendly as he had been in administrative interactions.

Relationships between nursing personnel and patients showed a high

FIGURE 8
SOCIALIZATION OF NURSE WITH PATIENTS
COMPARED ACCORDING TO TYPE
INTERACTION



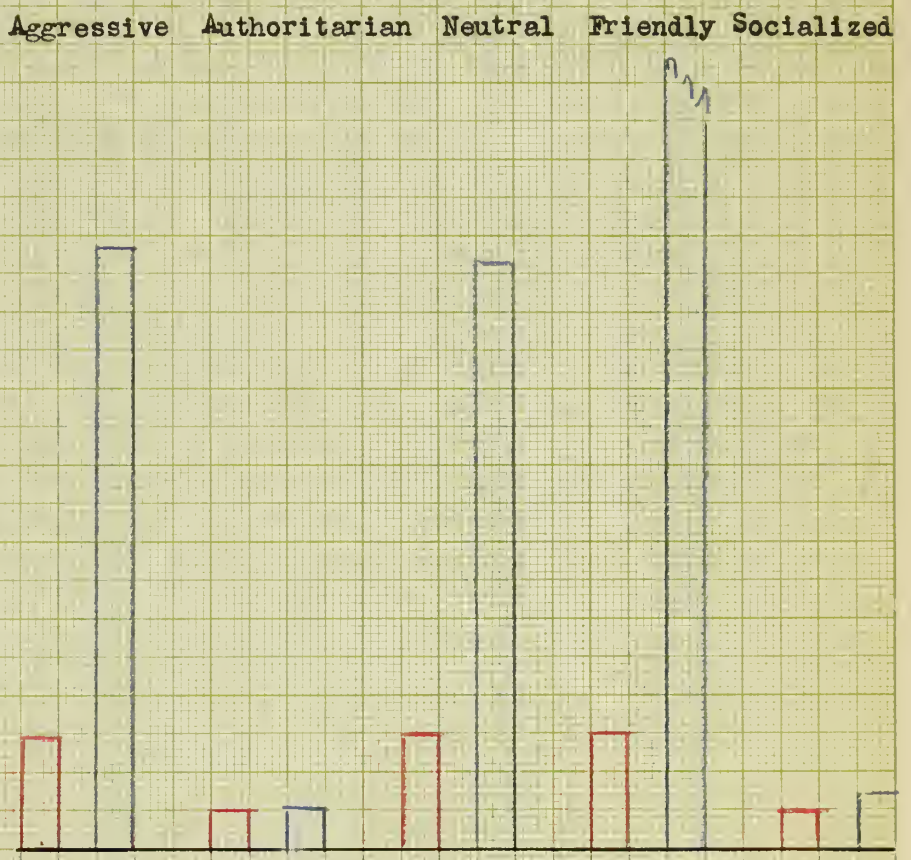
Key
1 sq. - 1/5 interaction

Administrative Interactions

Non-Administrative Interactions

Source: Compiled from information Table 8, Appendix

FIGURE 9
SOCIALIZATION OF PATIENT WITH NURSES
COMPARED ACCORDING TO TYPE
INTERACTION



Key
1 sq. - 1/5 interaction

Administrative Interactions

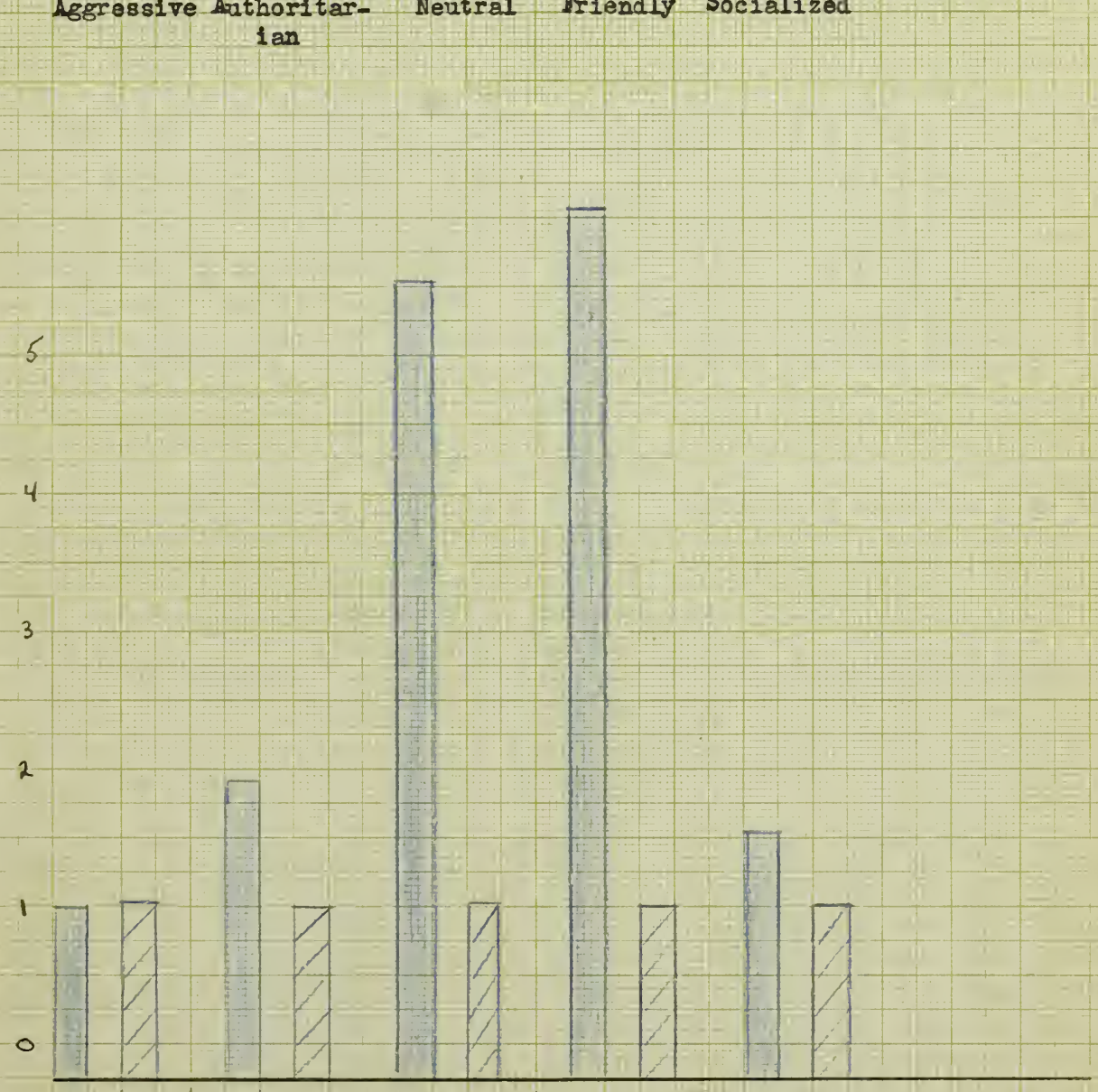
Non-Administrative Interactions

Source: Compiled from information Table 8, Appendix

degree of socialization exposing a friendly basis for establishing rapport. It has been seen that once again the administrative role of the nurse is characterized by authoritarian, neutral quality. The patients' aggressiveness in administrative capacity may be in resistance to the authoritarianism of the nurse whereas the absence of authoritarian quality in the patient may possibly be in submissiveness to or acceptance of the nurse as such a stereotype. In the relationship between the nursing personnel and patients, the individual nurse is actually socially more effective than the patient; not only does she originate more frequently as a whole but she is five times as friendly to the patients as the patient is to her (see Figure 10).

Interpersonal relations among patients. The patient intragroup interactions comprised the largest single force in the social group. Although administrative patient-patient interactions were almost negligible (see Table 7 in Appendix), it may be significant that when they occurred they were neutral or friendly. An analysis of the entire patient-patient interactions without consideration of types of interaction would, then, present a sufficiently accurate picture of the socialization process among the patients. These interactions were highly socialized, moderately neutral, at times aggressive and even less so authoritarian. Although the aggressive quality comprised 13 per cent, authoritarian 2 per cent of all patient-patient interactions, the friendly quality comprised the largest factor. As shown in Figure 11, each patient originated twice as many friendly interactions to peers as either neutral or socialized interactions. This appears to be more wholesome socialization than might be expected on an acute service and differs from the usual textbook picture of the person who is acutely mentally ill.

FIGURE 10
SOCIALIZATION NURSE COMPARED WITH
SOCIALIZATION PATIENT IN
NURSE-PATIENT RELATIONSHIP



Key
4 sqs. - 1 interaction
Nurse-Patient
Patient-Nurse

Source: Compiled from information in Table 9, Appendix.

FIGURE 11
SOCIALIZATION PATIENT WITH PEERS

Key
1 sq. - 1 interaction

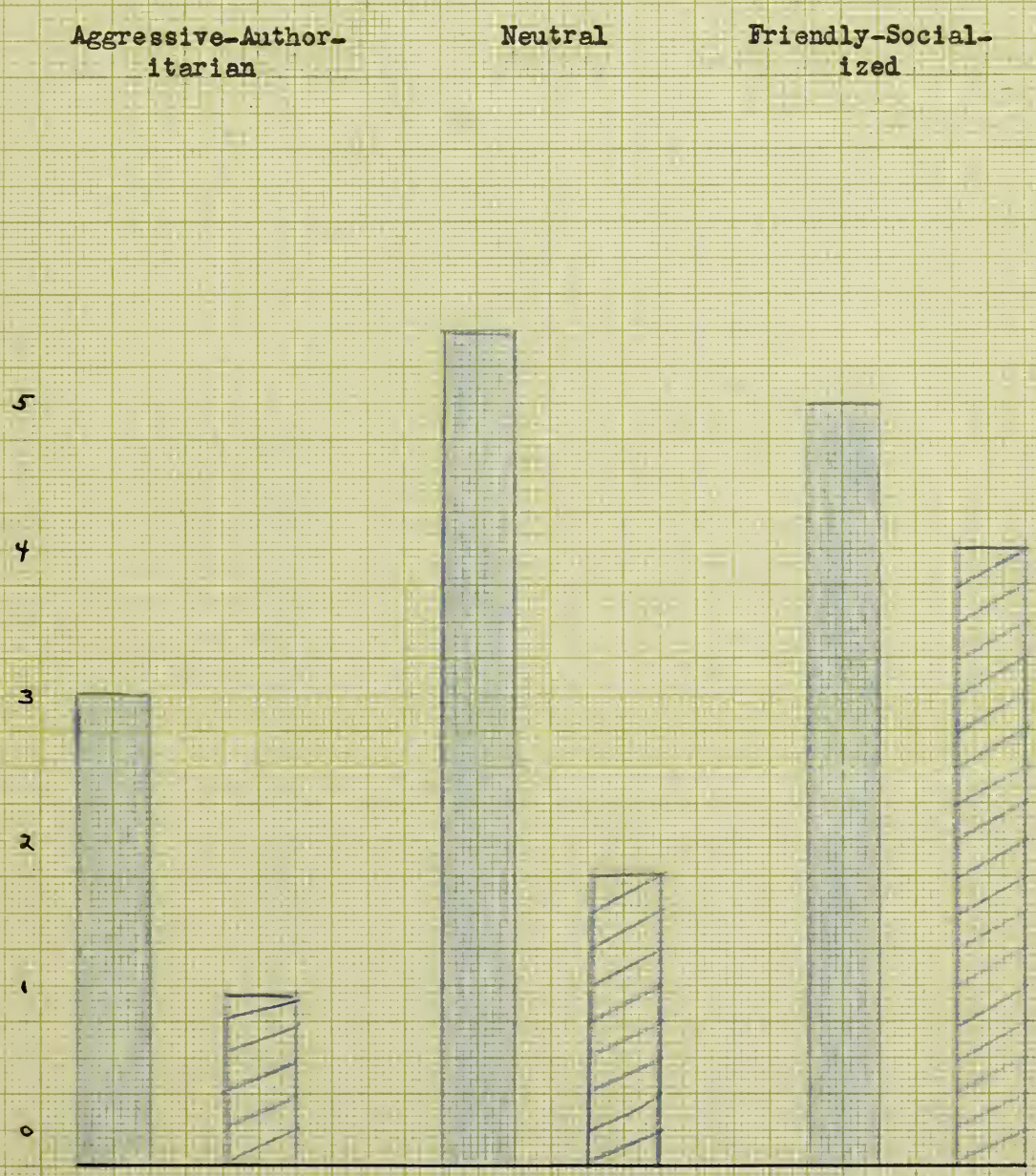
Source: Compiled from information in Table 7, Appendix.

Socialization of the patient contrasted with socialization of the nurse. The nurse and the patient appeared to be friendly-socialized persons whose neutral and aggressive-authoritarian behavior were approximately in a ratio of two to one respectively as shown in Figure 12. However, in comparing their total reactions in Figure 13, the nurse was somewhat more friendly but only one-third as socialized; although their aggressiveness was similar, the nurse's authoritarianism was far more intense and her neutrality more noticeable than the patient's.

As previously described (page 46) and portrayed in Figure 10, the high rate of interaction and the friendly-socialized nature of the nurse-patient relationship was promoted more by the nurse than by the patient. Behavior among patients contrasted with behavior among nurses shows that the former was more friendly-socialized and the latter more authoritarian-neutral (Figure 14). It appears that socialization among patients may be in social imitation of nurse's relationship with patient and the friendly atmosphere of the community. Relationships among nursing personnel (see page 39) were fairly harmonious but did not compare favorably with the relationships among patients (see Figure 14); this difference may be attributed to the large percentage nurse-nurse interactions which were administrative (Figure 6 illustrated the authoritarian-neutral characteristics of administrative interactions). The same explanation may account for the contrasts in Figure 15 wherein the patient is more socialized with nurses than the nurse is with her peers. Figure 16 shows that the nurse was more authoritarian and neutral, more friendly and socialized toward patients than toward peers. This might be expected in as much as the nurse-patient interactions were in a ratio of 3 non-administrative to 1 administrative, whereas nurse-nurse

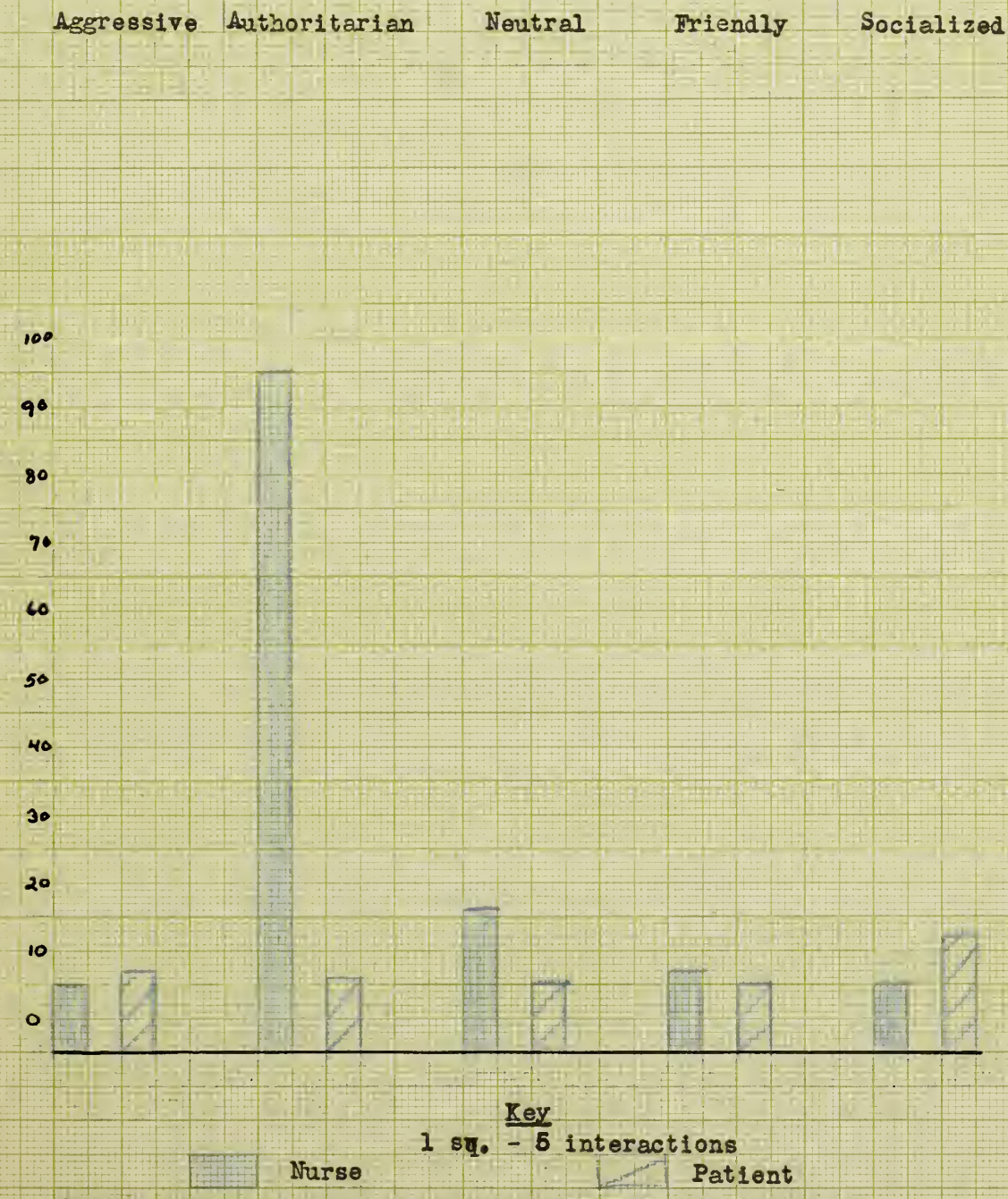
FIGURE 12

NUMBER INTERACTIONS ORIGINATED BY EACH PERSON ACCORDING TO QUALITY



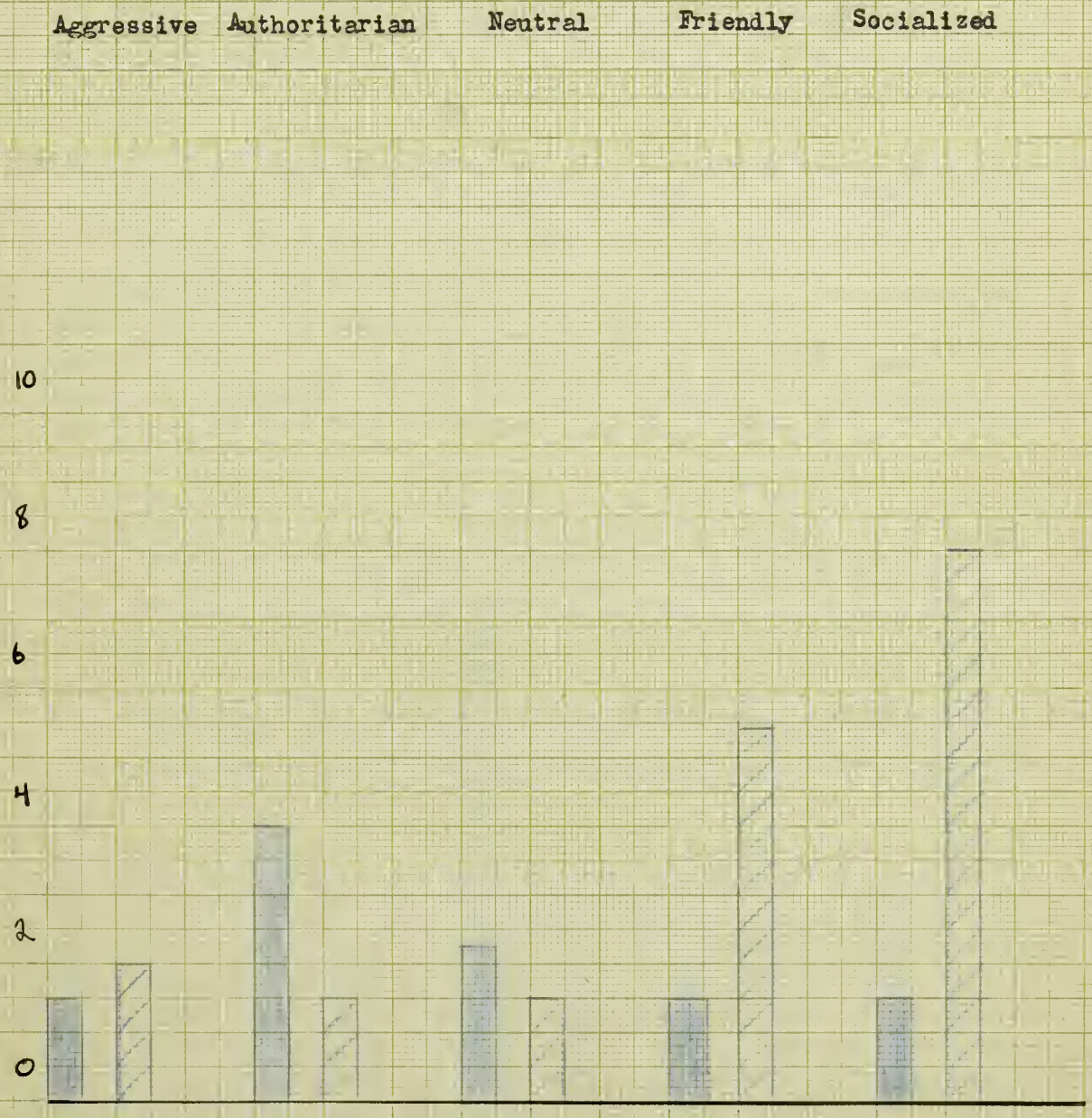
Source: Compiled from information in Table 9, Appendix.

FIGURE 13
SOCIALIZATION NURSE COMPARED WITH
SOCIALIZATION PATIENT



Source: Compiled from information in Table 9, Appendix.

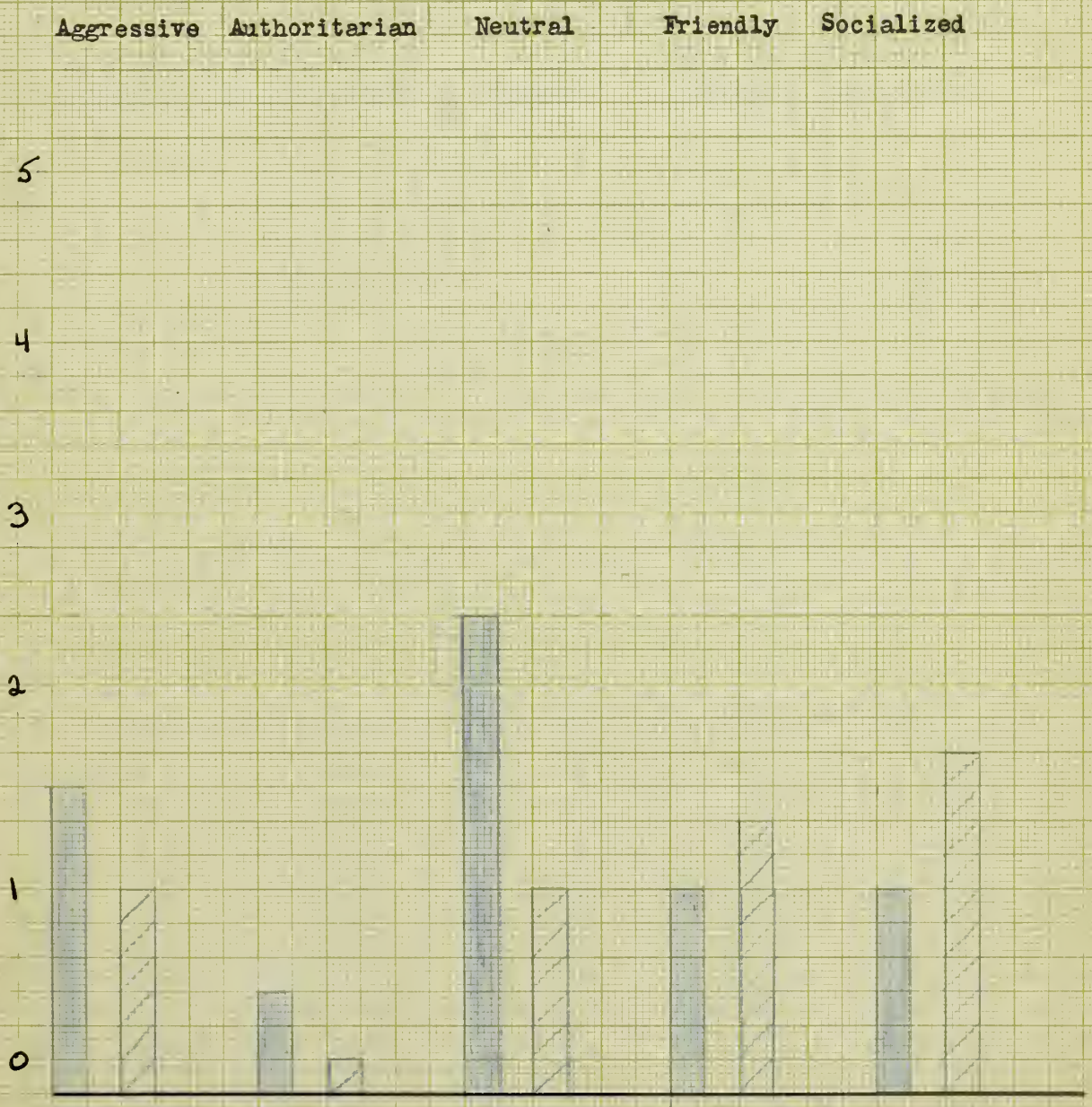
FIGURE 14
SOCIALIZATION OF PATIENT WITH PEERS
COMPARED WITH SOCIALIZATION
NURSE WITH PEERS



Key
1 sq. - 1/2 interaction
Nurse
Patient

Source: Compiled from information in Table 9, Appendix.

FIGURE 15
SOCIALIZATION NURSE WITH PEERS
CONTRASTED WITH SOCIALIZATION
PATIENT WITH NURSES

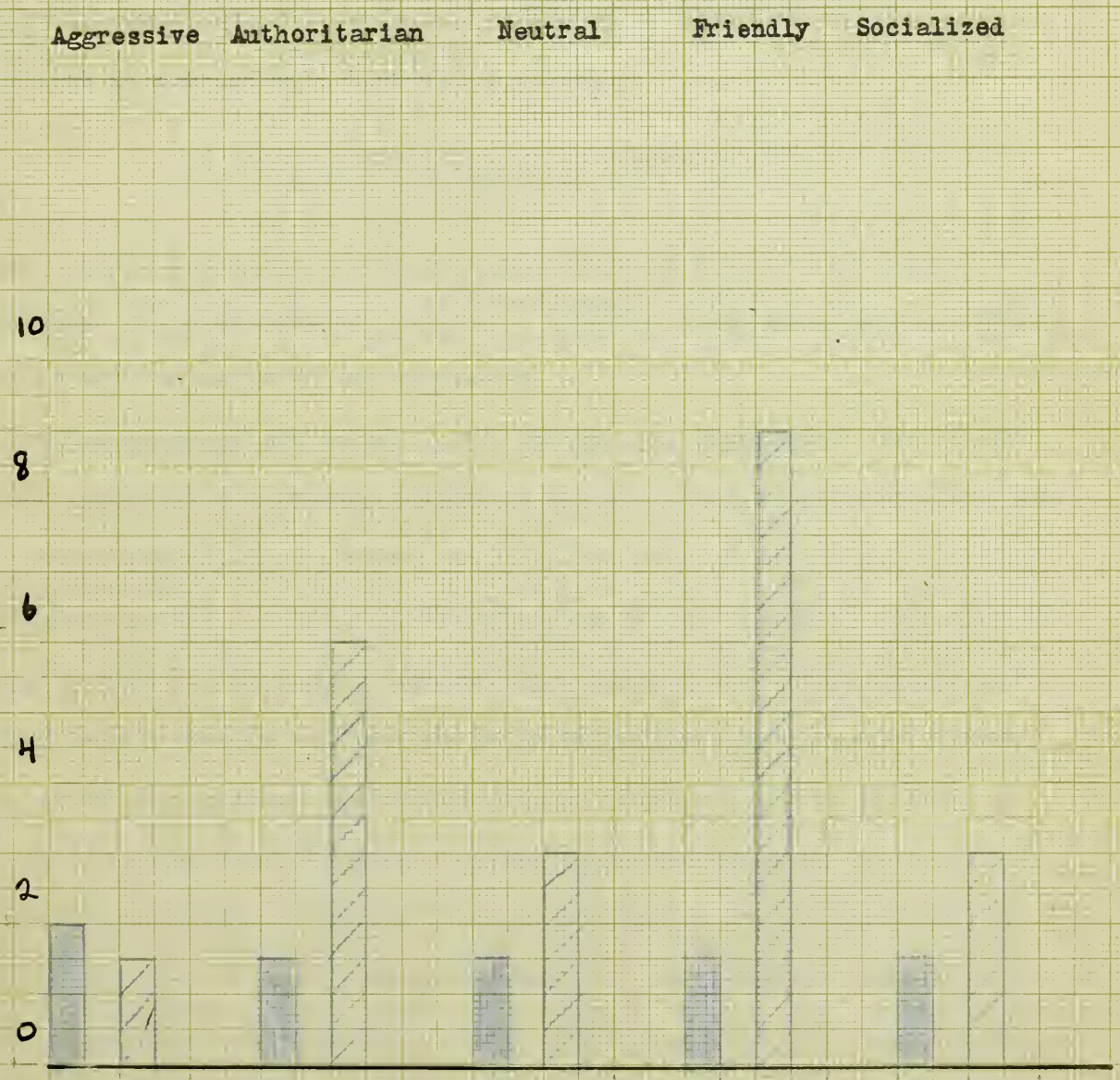


Key
6 sqs. - 1 interaction
Nurse-Nurse
Patient-Nurse

Source: Compiled from information in Table 9, Appendix.

FIGURE 16

SOCIALIZATION NURSE WITH NURSES COMPARED WITH SOCIALIZATION NURSE WITH PATIENTS



Key

2 sqs. - 1 interaction

Nurse-Nurse Nurse-Patient

Source: Compiled from information in Table 9, Appendix.

interactions had been primarily administrative. As shown in Figure 17, the patient displayed more overt behavior toward peers than toward nurses indicating he tended to be more spontaneous with patients than with nurses. On the whole, the behavior of other patients did not disturb him as much as it might generally be expected and as illustrated in Figure 18 he got along better with fellow patients than did the nurse.

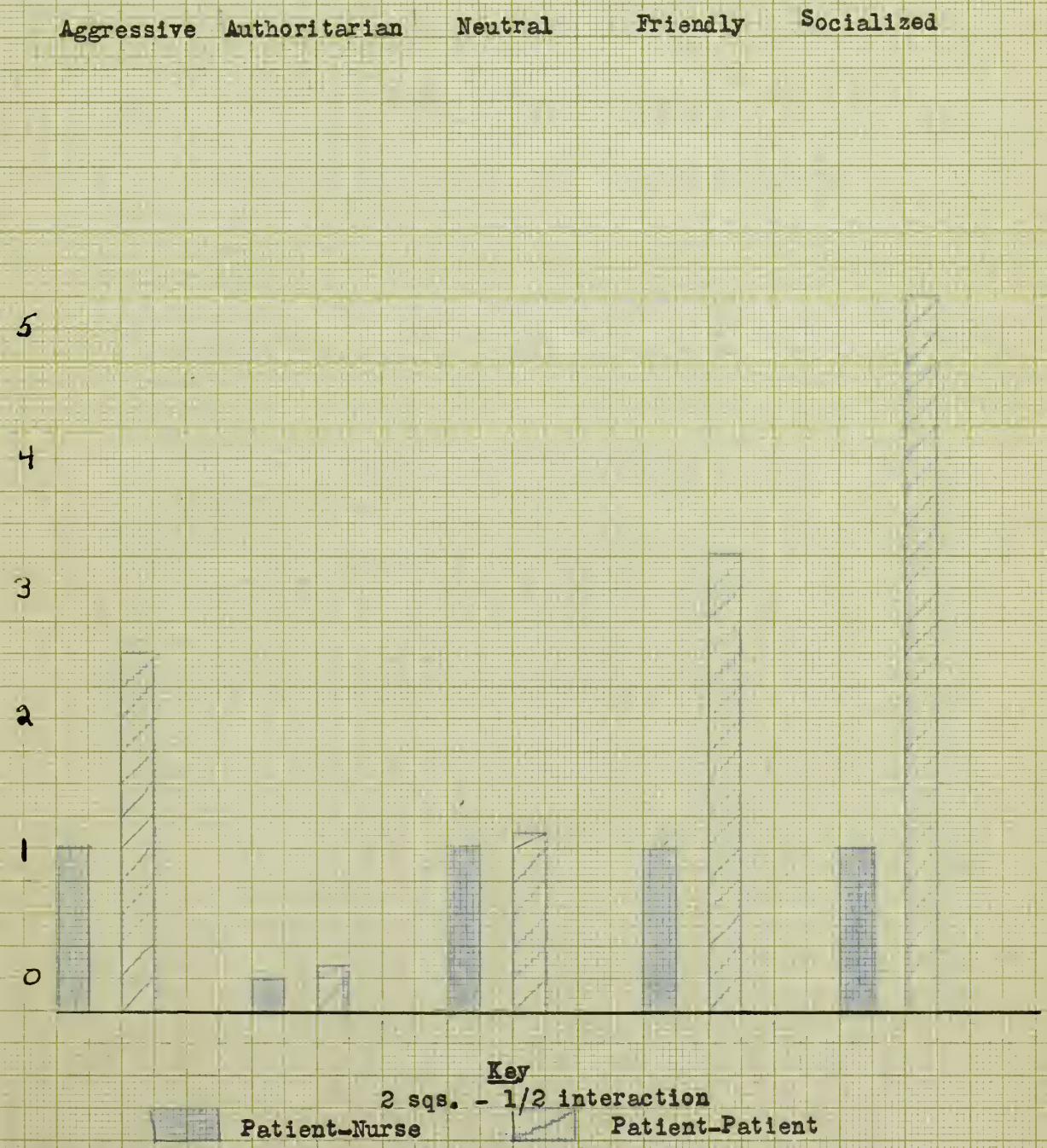
B. SUBJECTIVE ANALYSIS OF INTERACTIONS

Subjective appraisal of the nursing community may lead to further understandings of relationships involved. Specific examples of interpersonal relations will be selected and discussed.

Reintegration of one patient into the nursing community. One of the events observed in the nursing community was the skillful reintegration into the group of patient A by another patient, B. A brief resume may clarify the meaning of this. A had been brought back to the community following an attempt to escape. Utilizing "protective measures" the nursing personnel isolated her, a process carried out in an authoritarian-aggressive manner which was met by counter-aggression from A. Within the next fifteen minutes, A's mother visited her. Patient B who had observed A's previous state of unhappiness, joined with her own visitor to have a brief but friendly chat. After the visitors had left, B took A for a stroll within the nursing community. Strolling about they encountered C who was tearing her clothes and stuffing the pieces through the window guard, cussing and swearing at her own created "enemies" outside. Taking A's hand, B said, "Let's go talk with C." At first C vented hostility but B was accepting of this and at the same time reassuring to A. Shortly the three were con-

FIGURE 17

SOCIALIZATION PATIENT WITH NURSES
COMPARED WITH SOCIALIZATION
PATIENT WITH PEERS

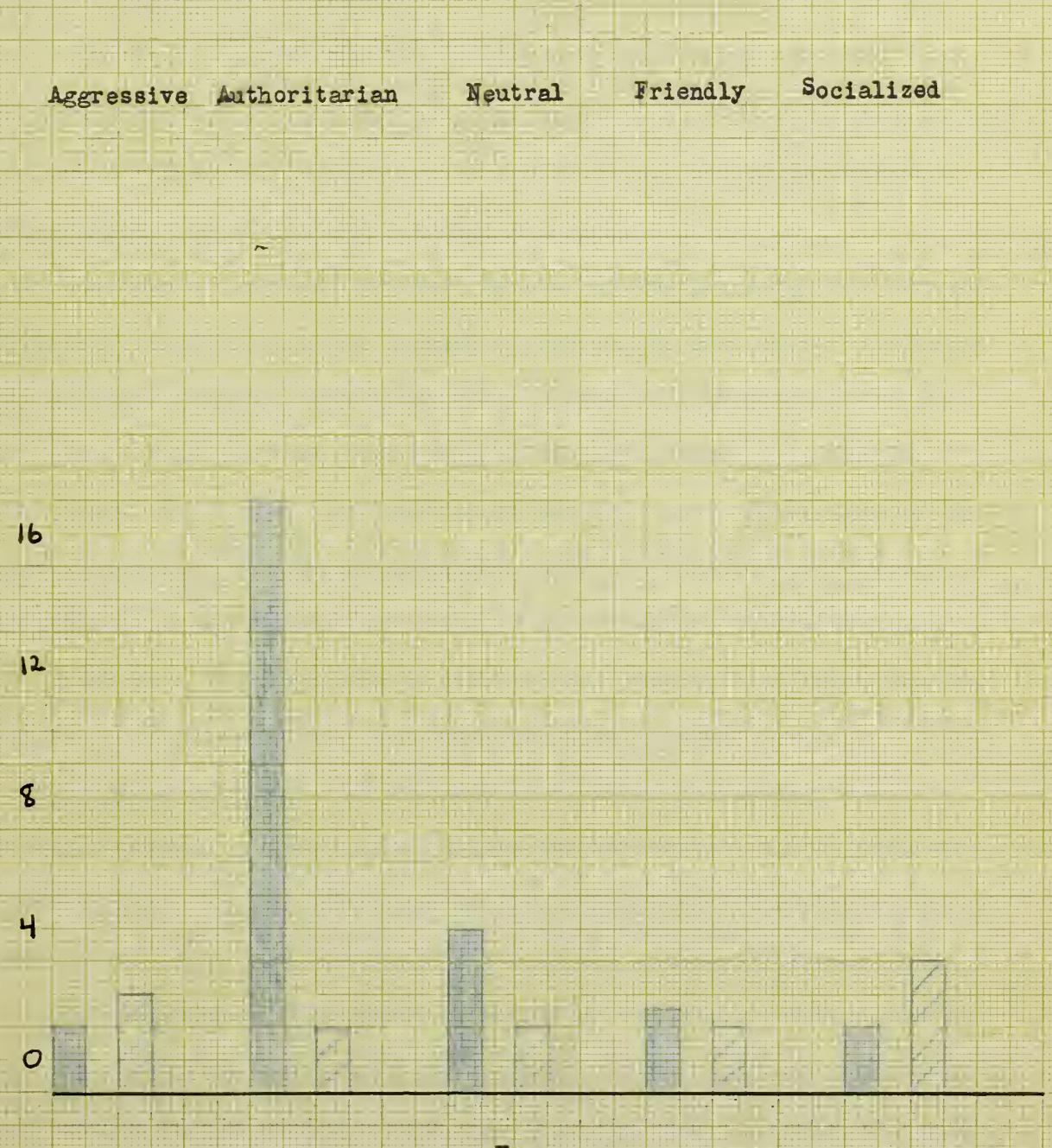


Key
2 sqs. - 1/2 interaction
Patient-Nurse
Patient-Patient

Source: Compiled from information in Table 9, Appendix.

FIGURE 18

SOCIALIZATION PATIENT WITH PEERS
COMPARED WITH SOCIALIZATION
NURSE WITH PATIENTS



Key

1 sq. - 1 interaction

Nurse-Patient

Patient-Patient

Source: Compiled from information in Table 9, Appendix.

versing. When C became upset again by her "voices," B did not sustain her efforts and the two withdrew. B's friendly backward glance attracted A's attention at which time B suggested she make herself comfortable in the Lounge. In the Lounge, B took A to a chair, turned on the radio and reassured her before leaving. Other patients spoke to A; a conversation was in process when B returned to look over the situation. She smiled at the group and left A to continue her social progress.

A had been a "rejected patient" by the nursing personnel but she had continuously received security through acceptance by her peers. Attitudes of the nursing personnel toward her were incongruous, frequently showing ambivalence. A in turn had used personal hygiene aspects as a weapon against them. Psychogenic dysfunction of her legs was another area of considerable annoyance but the patients had their own code for preventing other patients from rejecting A. If such were about to occur, the group would "break it up" through wit or overt verbal loyalty to A until the instigator had conformed to the expectations of the group.

"Privileged patient." In contrast to A, D had originally been a "privileged patient." The nurses thought she was "cute" and had made concessions to her. Rivalry developed between A and B for attention of the nursing staff. This was not completely resolved although its resolution was considerably hastened by positive action of the group. D resisted the group, i.e.; she would have nothing to them. It was not long before she was an isolate in the nursing community. By this time, her demands caused a reversal of nurses' attitudes. This was an unbearable experience for D apparently because her social hunger sought satisfaction. This in turn brought a favorable change of behavior in her and permitted establishment

of relationships on a new footing with both her peers and the nursing personnel.

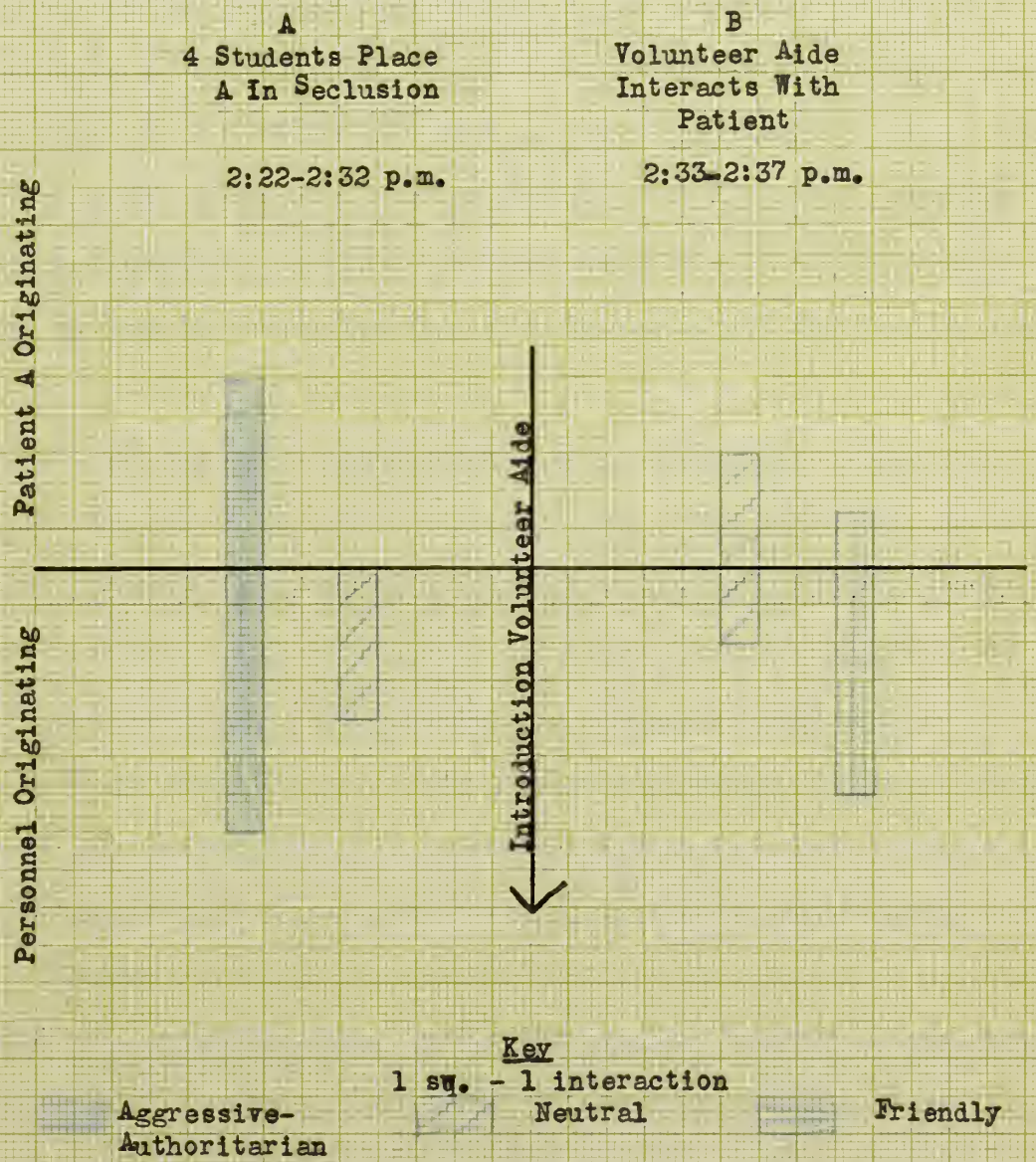
Permissiveness and social mobility of the group. E's behavior presented many real problems many of which had been resolved; however, her verbose and vulgar conversations with her "voices" sporadically caused considerable concern because the nursing personnel felt that these episodes upset the patients, presenting to the nurses a dilemma for if they secluded her, she remained out of contact with reality longer, having only her voices to attract her attention.

Sociometric observations showed that the social mobility of the group permitted patients who might be upset to withdraw from the subgrouping where E was and that the structure of the group demonstrated permissiveness. These two factors should tend to make counter-aggression unnecessary. Figure 19A illustrates that nursing personnel did not fully understand this, for seclusion was instigated following this decision, "We'll have to put her in seclusion. She's upsetting the other patients." The nurses' aggressiveness was met by E's counter-aggressiveness; however, as shown in 19B, the warm, friendly approach of the Volunteer Aide brought a marked change in E's behavior.

Therapeutic value of authoritarian approach. Authoritarian approach appeared to have not necessarily a destructive effect. A certain amount may be necessary so that conditions approximate those the patient might be expected to deal with outside the hospital community. The following resume illustrates the therapeutic value of such an approach when the general atmosphere is wholesome and security-giving.

F had launched into G with a verbal attack of accusations. Tension had

FIGURE 19
MODIFICATION PATIENT'S BEHAVIOR



Source: Interactions from one fifteen minute sociometric observation were classified. The diagram reflects contrasts in the patient's behavior brought about by two different approaches.

mounted when the student nurse entered, demanding, "What's going on here?" As soon as she had left, F resumed her attack which was again interrupted by the student, with hands on hips, saying, "Will one of you go in the other room. We can't have this here!" As soon as she left, G said to her antagonizer, "Well, at least we said what we had to say," to which the other agreed and both laughed. For fifteen minutes there followed a period of G rejecting attention F was extending to her. Forty-five minutes afterwards the two were observed in another area carrying on a "chit-chat." From there on their relationships improved and broadened into a friendship. Although G was shortly transferred to another nursing community each looked forward to seeing one another at activities that were shared by all the nursing communities.

The student had apparently appeared at the psychological moment when tension between the two patients was at its height. This energy was drained off through the student's authoritarian approach. In turn, the energy was spontaneously displaced onto the student, creating of her a scapegoat. By this time, F, the instigator, was experiencing remorse as evidenced by her contrast of behavior toward G, i.e.: she offered cigarettes, commented about magazines, and paid attention to G's comfort. This in turn was rejected allowing a leveling-off period and time to reestablish their relationship on a more wholesome basis.

The nurse as a catalytic agent in patient relating himself to the group and the group relating itself to the patient. It appeared that persons who had lobotomies might have been isolates in the nursing community had it not been for the nursing personnel who acted as catalytic agents in formation of relationships. This was done so successfully by one nurse with H that even

prior to the removal of the bandage the group was looking out for H. During one sociometric observation, the patients were alone except for the observer. H began picking and pulling on her bandage. Several patients attempted to bring this to the attention of the observer, "Look, Nurse, look at this--see what H is doing." The observer gave no apparent response so the leader of the group said, "That's it--go ahead, take it off, H." H grinned and stopped pulling the bandage as the leader moved over on the same sofa. Conversation continued as before with H looking up and grinning from time to time.

The acceptance of the observer by the group. It appeared that the observer was accepted as a non-participating group member. Some indication of this has previously been given on page 29. During one structuring process, it was particularly apparent. A large proportion of the group in the nursing community had already gathered in the lounge when the observer entered. As soon as structuring was initiated, J began explaining to everyone what the observer was doing:

> She wants to study us...she's studying me--see I can tell you just why she wants to do it. See that pencil and see that paper. I shall tell you what she is about to do. As I talk she will take down everything I say--everything, mind you. Not only will she take down everything I say but everything I do--not only me but you. She's very much interested in studying our reactions--how I react to you and you to me. If someone comes in that door there, she'll take that down too. Now mind you.

This brought a great deal of response from the group: patients laughed, and several commented to the observer. One patient with feeling and concern re-

marked, "Don't let it bother you, Nurse." Another one said, "If you can take down everything that woman says, you'll be in here before you know it." A third patient offered further suggestion, "Just don't pay any attention to her, Nurse--it's none of her business."

The understandings gained through analysis of the sociometric study have indicated activities at the process level which were in keeping with the concept of the nursing unit as a community, a concept previously described in chapter 2. These understandings will be further clarified in the summary and recommendations.

SUMMARY, RECOMMENDATIONS AND CRITERIA

A survey of the literature pertaining to interpersonal relations in psychiatric nursing has been presented. Conceptual schema viewing the nursing unit as a community has been applied to a specific Head Nurse Unit, illustrating, through the use of a sociometric observation technique, the various interrelationships among the patients, among the nursing personnel, and between the two. These in turn have been analyzed through two different but complementary avenues--the objective and subjective approach. The results of this analysis will be presented as well as the interpretations from the analysis of the educational program for basic professional student nurses having their affiliation at the hospital where the study was conducted. Recommendations will be suggested for eliminating the variations between the content of the clinical situation and the content of the planned educational program, indicating potential effects expected upon which evaluation might be made.

A. SUMMARY OF ANALYSES

The sociometric analysis of the nursing community. The sociometric analysis points in the direction of the existence of many forces and processes, one of which concerns the atmosphere of the nursing community. This appears to play an important role in stimulating relationships among its members that approximate the average family. The social situation does not appear to be too different from the type of situation with which the patient is expected to cope outside the hospital community. It has a noticeable

security-giving quality, although it lacks some of the characteristics of the ideal, closely-knit family situation. It has, however, such characteristics as "sibling rivalry" and scapegoat formation instigated through "privileged" and "rejected" patients as well as the use of food, sleep, etc. as weapons.

If the nursing community resembles the family, it is a wholesome family group as evidenced by the reestablishment of emotional equilibrium because of the neutralizing forces which checked excessive hostility and aggression. The development of social concern and interest in others as well as the freedom of spontaneously formed sub-groupings indicates the development of inner controls stemming directly or indirectly from the structure of the group. When authority is derived from the group, primary group codes evolve which permit reestablishment of more wholesome relationships. Social mobility and social hunger play an important role in meeting and modifying behavior of the group: the one making counter-aggression unnecessary and the other providing a strong incentive for improvement.

The nurse's therapeutic role appears to be derived from her catalytic powers in the patient relating himself to the group and in stimulating socialization among the patients through a wholesome nurse-patient relationship. Recognition is given of the weakness of the nurses in certain situations; however, as socio-psycho-biological organisms they, too, produce tensions which tend to be either inhibited or released. For the most part, they tend to release their tensions within their own group. There is some indication that their attitudes toward individual patients influence the quality of their nursing. This seems reasonable when considering the essence of psychiatric nursing, interpersonal relations. The nurse appears to be "role playing," i.e.: her behavior is different in administrative

role as contrasted to her behavior in non-administrative role. This may be an area of role-conflict in psychiatric nursing. Her behavior in administrative role appears so consistent in this study that there may be some correlation between that and earlier conditioning in carrying out orders and routines. The nurse's capacity for socialization becomes more noticeable in her spontaneous role. Although she does little to have the patients share responsibilities concerning schedules and routines, it appears she makes routines subservient to spontaneous interpersonal relations.

The foregoing presents evidence indicating that therapeutic values are scattered throughout the membership of a nursing community, pointing to both the nurse and the patient as therapeutic agents and to the acceptance of a neutral non-participating nurse-observer as a member of the psychiatric nursing community. Many factors relating to the dynamics of the group are constantly at play. Contrasts in the socialization ability of the same nurses in two divergent roles, namely administrative and non-administrative roles, reveals an unexplored area in interpersonal relations in psychiatric nursing.

Analysis of the educational program. The basic professional student nurses having experience in psychiatric nursing are affiliated from general hospitals within the neighboring territory. The content of the psychiatric nursing curriculum closely parallels the recommendations of the professional nursing educational organizations and the local approving body, i.e.: recommendations of Curriculum Guide for Schools of Nursing[1] and Massachusetts State Board of Nurse Examiners. The theoretical content includes more pertaining to psychological testings than the former recommends. A large pro-

1. Last published in 1938 by National League of Nursing Education.

portion of the curriculum is devoted to the teaching of neuroanatomy and allied pathologies, minor personality deviations, procedures for the somatic therapies. At the time of the study, attempts were being initiated to introduce the student to the sociometric observation technique. This was related to the student's participation in medical research in lobotomies. Further consideration was being given to relating this teaching to nursing needs.

The clinical content consists of experiences in the varied nursing communities with special assignments such as somatic therapies, admissions, and field trips to community agencies such as sheltered workshops. Students share experiences with occupational therapists working with the patients. Although students are rotated through experiences at short intervals, the continuous experiences with occupational therapy seem to provide continuity alleviating some difficulties in interpersonal relations which might stem from such frequent rotations. Assignments within the Head Nurse Unit are made within the framework of nursing responsibilities related to personal hygiene and property, medications and treatments, housekeeping, observation precautions, and other aspects concerning administration of the unit.

Clinical teaching tends to center around nursing problems not necessarily related to interpersonal relations with the exception of the spontaneous discussions which stem from the situation. These discussions are particularly evident in the occupational therapy units and in relationships of the students to the social workers and psychologists. Students attend staff and admission conferences. These may or may not be oriented to psychiatric nursing; when they are, students tend to participate, but their participations tend to be abbreviated. Students rotate with other depart-

ments in presenting the staff conference at which time they consider how nursing care has contributed to the therapeutic program of one patient.

Teaching methods consist of lectures, clinics, nursing care conferences, symposia. Closer correlation of classroom with the clinical situation is being initiated through having the Head Nurses participate in both. Classes tend to be based on carefully prepared lesson plans. For the most part, methods used in the student nurses' classes are in contrast to those used for the psychiatric aide or attendant group. The non-professional nursing personnel's educational preparation centers around group discussions and nursing problems they are meeting from day to day. Therein authority is transferred from the leader to the group. Although it is too soon to evaluate these group discussions, there are sufficient indications that the attendant is able through them to gain insight and understandings difficult to achieve through the more static methods of teaching.

The foregoing analysis indicates that the content of the basic professional student nurses' curriculum is oriented primarily to individual psychology and somatic aspects of psychiatric nursing. There appears to be lacking content related to interpersonal relations except for the experiences spontaneously shared. Longer experience on a nursing community would seem preferable to a variety of experiences where the student does not have continuous, face-to-face contacts with the same patients. Teaching methods, with exception of those areas indicated, are the type that do not necessarily provide opportunities for the release of the spontaneous potentiality of the group of students. It appears that if the student is to gain insight into interpersonal relations, teaching "methods" must transfer authority from the leader to the group so that in turn the student may learn to derive

authority from the situations in which she is having experiences.

B. RECOMMENDATIONS

The gaps that appear between the clinical content and the content of the educational program are concerned primarily with factors relating to interpersonal relations. It is clear that the psychiatric nursing practitioner needs skill in observing, interpreting, and communicating to others and should be prepared to become aware of her own effect upon the group as well as the effect of the group on her own behavior. It becomes evident that in the preparation of the psychiatric nurse, as well as in preparation of the basic professional student, experiences should be provided for her to develop these skills and awarenesses. This would necessitate flexible, growing, and purposeful direction of activites leading to such aims. Inclusion of principles of group dynamics and opportunities to recognize and apply these principles would appear to bring enrichment to the preparation. Because of the evolving content in psychiatric nursing, this would necessitate research, perhaps immediately individual nurses making studies in field resources where such enrichment of the program is anticipated.

Although proposals here are limited to one group of students, namely those enrolled in basic professional nursing curriculum and are further limited to the structural unit of curriculum in which student is concerned, there are many broad implications concerning nursing education. Many improvements may be included in the curriculum plans for the introductory course for students being prepared to enter psychiatric nursing as well as general nurses preparing as psychiatric nursing practitioners, teachers, and administrators on various levels. There is evidence also that in-service

program is needed for nurses already engaged in psychiatric nursing which will contribute to their understandings of interpersonal relations. This should be extended to meet the needs of other workers in the nursing team so all personnel may have common understandings. It is recognized that as rapidly as possible attention must be given to increased emphasis on interpersonal relations at an earlier stage in the program. It seems advisable, however, to concentrate on this limited aspect of curriculum until more extensive and intensive information is available upon which to base the integrated plan.

C. CRITERIA

At the present time, means of evaluating such a program in action are needed. It seems reasonable that the success of such a plan may be indicated by the improvement in the nurse's skills in interpersonal relations. The degree of improvement would be dependent upon her own personality growth and level of maturity. Skills of communication and a sensitivity to relationships would be involved. For instance, students who are having the proposed enriched program, might be expected to make a better adjustment to the psychiatric nursing situation; they would tend to develop more readily wholesome relationships with the patient and with others in the clinical team. They would tend to feel more with "one-ness" in relating themselves to the psychiatric nursing community, recognizing their limitations as well as their potentialities. As they would become more aware of their own behavior, they would tend to recognize indications and significance of resolving their conflicts in the social setting. This would in turn lead on to more acceptance and understanding of the persons within the nursing com-

munity. As these growth processes are released, the students' experiences with the patient would be less marked by subjectivity so that counter-aggression would not be as necessary, allowing them to assimilate experiences in terms of a meaningful whole.

Although quality care, as evidenced by these factors, may be subjected to misinterpretations and misunderstandings, it can be expected that applied social science research in this area will expose further elements in the situation to assist in clarifying and structuring an evolving content in psychiatric nursing.

APPENDIX

FIGURE 4
SAMPLE OF METHOD OF CLASSIFYING
DATA IN A SOCIOGRAM

SOCIOGRAM #18

Date: June 16, 1948
Place: Nursing Unit #3, Lounge
Time: 11:15-11:30 a.m.
Setting: Some of patients had gone to dinner

UNITS OF ACTION			NUMBER OF INTERACTION	CLASSIFICATION: ORIGINATION: Nurse to nurse	ORIGINATION: Nurse to patient	ORIGINATION: Patient to nurse	ORIGINATION: Patient to patient	TYPE: Administrative	TYPE: Non-Administrative	QUALITY: Aggressive	QUALITY: Authoritarian	QUALITY: Neutral	QUALITY: Friendly	QUALITY: Socialized
	S4 to 38:	"Your cigarette burned out."	1		x				x				x	
	38 to S4:	"I couldn't have--I talked too much. I didn't have time to smoke it."	2			x			x				x	
1	S4 to 38:	"You didn't smoke it--you layed it there, and it burned out."	3		x				x				x	
	38 to S4:	"Oh," points finger in air and smiles.	4			x			x				x	
	19 to 38:	Entering, "She's living in sin--this is hell. Going now...see you later."	5				x		x	x				
2	Pts to 19:	All pay attention, smile and laugh, talk among themselves.	6				x		x					x
	24 to 19:	"Bye now--come back to see us."	7				x		x				x	
	2 to S4:	Moves to lounge, puts head on S4's lap.	8			x			x				x	
3	S4 to 2:	Puts arm around her. Talk about one of patient's plans to get married	9		x				x				x	

Source: Compiled from sociogram #18.

Explanation: This shows the classification of the raw data from the first 3 units of action in the sociogram. As can be seen, this involved classifying each of the 9 interactions according to origination, type, and quality. In this way, it was possible to transfer classified data from each sociogram to the Master Classification Sheet.

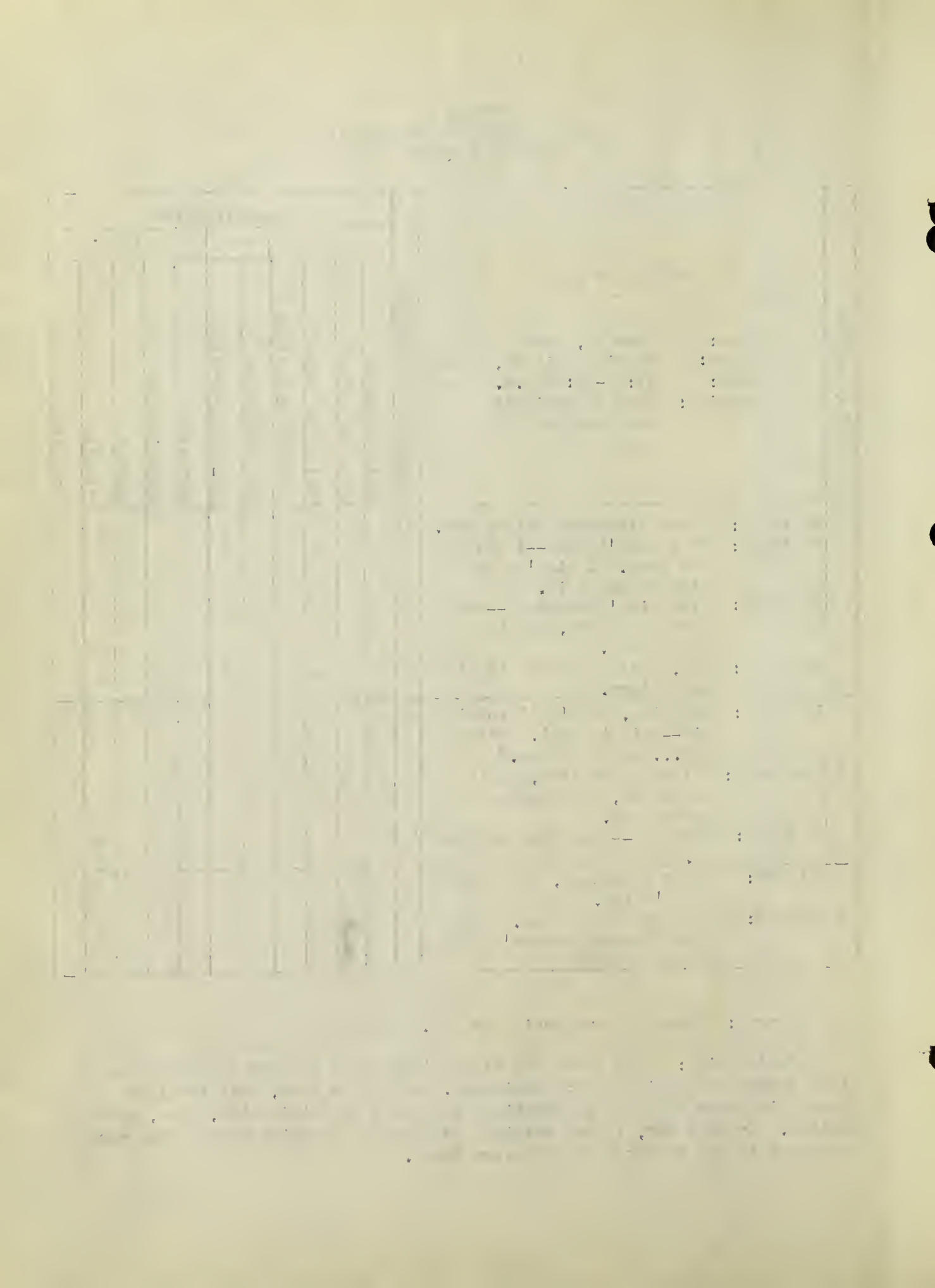


TABLE 2
MASTER CLASSIFICATION SHEET

ORIG.	TYPE	QUALITY	NUMBER INTERACTIONS IN EACH SOCIOGRAM. NUMBERS 1-23	QUALITY	TYPE	ORIG.
Nurse : Nurse	Administrative	Aggressive	1	1		
		Authoritarian	2 4	6		
		Neutral	1 4 2 2 5 6 9	29	39	
		Friendly	30	3		
		Socialized		0		
	Non-Administrative	Aggressive	2 1 1 1	6		57
		Authoritarian		0		
		Neutral	2 1 1	4	18	
		Friendly	1 1 2 1 1	6		
		Socialized	1 1	2		
Nurse : Patient	Administrative	Aggressive	1	1		
		Authoritarian	5 9 4 2 1 3 1 1	26		
		Neutral	1 4 3 7 3 5 2 3 5 1 2 6	42	80	
		Friendly	4 1 1 2	8		
		Socialized	1 2	3		189
	Non-Administrative	Aggressive	1 1 1	3		
		Authoritarian	2 2 1 1 1	7		
		Neutral	1 1 1 3 3 1 1 2 1 4 4 4 3 2	31	109	
		Friendly	4 8 1 1 2 1 8 9 3 10 9 3 7	66		
		Socialized	2	2		
Patient : Nurse	Administrative	Aggressive	1 1	2		
		Authoritarian		0		
		Neutral	1 3 1 1 1	6	9	
		Friendly	1	1		
		Socialized		0		116
	Non-Administrative	Aggressive	2 7 1 3 1	14		
		Authoritarian		0		
		Neutral	12 1 4 3 1 1 1 5 1 2 3 2 2 2	40	107	
		Friendly	2 1 2 2 2 2 1 4 1 1 7 3 2 3 6 2 1	42		
		Socialized	2 7 1 1	11		
Patient : Patient	Administrative	Aggressive		0		
		Authoritarian		0		
		Neutral	1	1	2	2
		Friendly	1	1		
		Socialized		0		306
	Non-Administrative	Aggressive	4 1 6 3 1 1 1 7 1 3 5 1 5	39		
		Authoritarian	1 1 1 2 1 1 1 5	7		
		Neutral	1 4 6 4 9 6 5 3 3 1 4 2 3 7 2 2	62	304	
		Friendly	0 9 11 5 17 3 9 14 5 2 5 2 10 1 9 5 16 12 7	142		
		Socialized	5 1 1 2 5 1 7 9 4 2 3 2 4 6 2	54		
TOTAL		NUMBER:	25 26 26 44 24 27 27 38 45 32 56 32 14 19 29 14 33 18 19 16 33 36 38	668	668	668

Source: Information tabulated from classification of raw data in original 23 sociograms.

Explanation: This shows the number of interactions in each of the 23 sociograms according to pathways of interaction and to type of interaction. In turn, this shows the quality for each according to the two-fold classification. To the right of the table, can be seen the sum total for each of the three classifications: quality, type, origination.

TABLE 3
SUMMARY ORIGINATION INTERACTIONS ACCORDING TO TYPE

TYPE	668 INTERACTIONS							
	18 Nurses Originating			62 Patients Originating			Ratio	
	No.	%	No/N	No.	%	No/P	Nurse	Patient
Administrative	119	48.7	6.6	11	2.6	.17	38.8	1
Non-Administrative	127	51.3	7.0	411	97.4	6.62	1.06	1
TOTAL:	246	100.0	13.3	422	100.0	6.8	1.9	1

Source: Compiled from information in Table 2.

Explanation: This shows the distribution of originations of the 668 interactions according to the number and percentage originated by 18 nurses in distinction to the number and percentage originated by 62 patients. The marked differences in the type of interaction originated by each group can readily be seen by comparing the distribution of the total number and percentage of each type originating in each group and from the average number per individual in each group.

TABLE 4
SUMMARY TYPE INTERACTIONS
ACCORDING TO ORIGINATION

ORIGINATION	668 INTERACTIONS							
	19.5°Administrative			80.5°Non-Adm.			Ratio	
	No.	%	No/Per.	No.	%	No/Per.	Administrative	Non-Adm.
N--N	39	30	2.15	18	3.3	1	2.15	1
N--P	80	61.5	4.44	109	20.3	6.	1	1.3
P--N	9	6.92	.14	107	19.8	1.7	1	12.2
P--P	2	1.5	.03	304	56.6	4.9	1	16
TOTAL:	130	100.0	—	538	100.0	—	—	—

Source: Compiled from information in Table 2.

Explanation: This shows the distribution of 130 administrative and 538 non-administrative interactions according to the number and percentage attributed to each of the four pathways of interaction. It illustrates the average number of each type of interaction per person. The pathways of interaction may be compared according to administrative or non-administrative interactions by noting the average ratio originated.

TABLE 5
SUMMARY TYPE INTERACTIONS ACCORDING TO QUALITY

QUALITY	668 INTERACTIONS											
	130 Administrative						538 Non-Administrative					
	No.	%	No/N	No/P	Ratio N	Ratio P	No	%	No/N	No/P	Ratio N	Ratio P
Aggressive	4	3	.1	.03	3.3	1	62	11.5	.49	.84	1	1.7
Authoritarian	32	24.7	1.7	0.0	1.7	0	14	2.6	.38	.11	3.4	1
Neutral	78	60	3.9	.10	39	1	137	25.6	1.94	1.64	1.1	1
Friendly	13	10	.6	.02	30	1	256	47.6	3.99	2.96	1.3	1
Socialized	3	2.3	.16	0.0	.16	0	69	12.8	.22	1.04	1	4.7
TOTAL:	130	100.0	___	___	___	___	538	100.0	___	___	___	___

Source: Compiled from information in Table 2.

Explanation: This shows the distribution of 130 administrative and 538 non-administrative interactions according to humber and percentage attributed to each of the five qualities. It can be used also to obtain the average number of each originated per nurse and per patient. The extent to which nurses are involved may be compared with the extent to which patients are involved by noting the average ratio of each group according to each category.

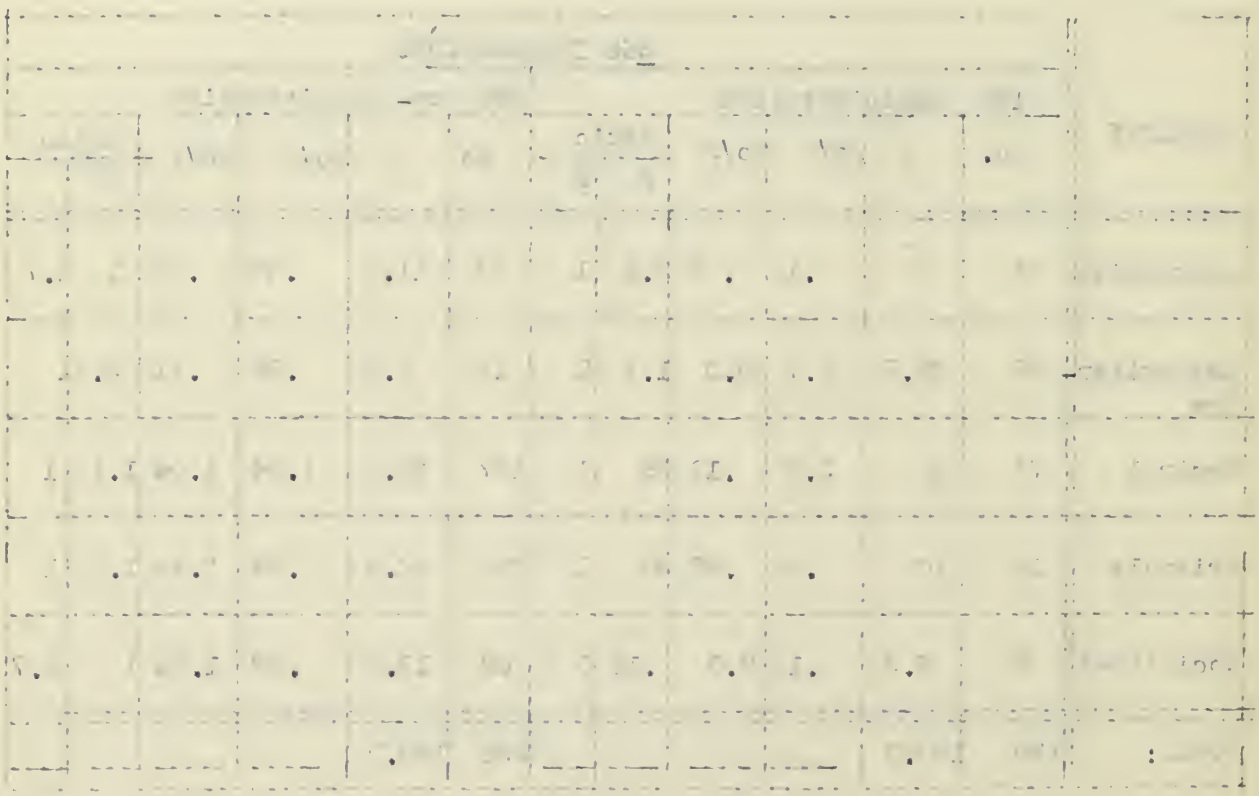


TABLE 6A
SUMMARY 668 INTERACTIONS
ACCORDING TO ORIGINATION

ORIGINATED BY	RECEIVED BY				TOTAL	
	NURSES		PATIENTS			
	No.	%	No.	%	No.	%
Nurses	57	8.5	189	28.3	246	36.8
Patients	116	17.4	306	46.8	422	63.2
TOTAL No.	173		495		668	
TOTAL %	25.9		74.1		100.0	

Source: Compiled from information in Table 3 and Table 4.

Explanation: This summarizes the total number and percentage of interactions according to whom and by whom originated. Vertical readings reflect number and percentage of interactions received by nurses or patients, and horizontal readings reflect the same for the source of origination.

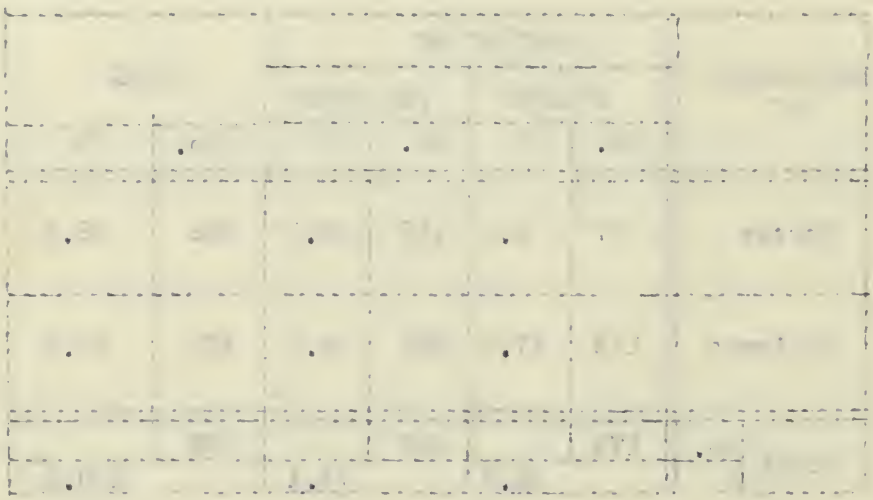
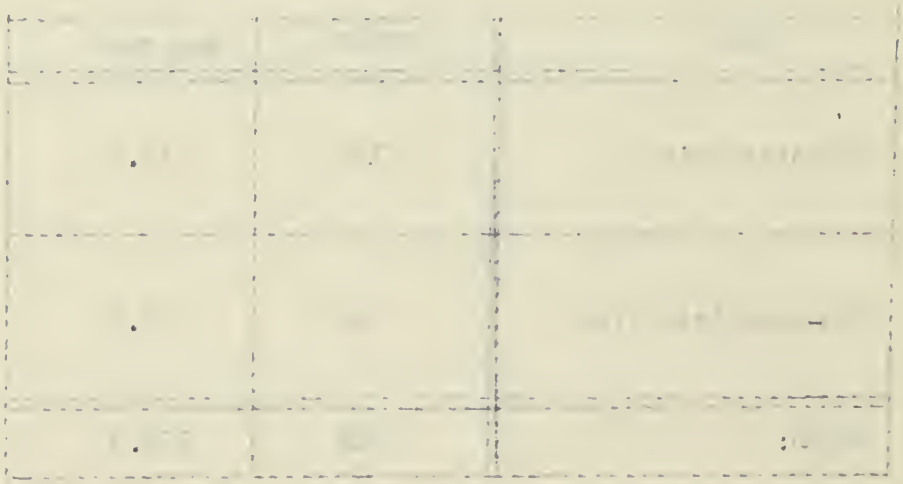


TABLE 6B
SUMMARY 668 INTERACTIONS
ACCORDING TO TYPE

TYPE	NUMBER	PER CENT
Administrative	130	19.5
Non-Administrative	538	80.5
TOTAL:	668	100.0

Source: Compiled from information in Table 4.

Explanation: This summarizes the 668 interactions according to the number and percentage of administrative and non-administrative interactions.



T A B L E 6C
S U M M A R Y 668 I N T E R A C T I O N S
A C C O R D I N G T O Q U A L I T Y

QUALITY	NUMBER	PER CENT
Aggressive	66	9.9
Authoritarian	46	6.9
Neutral	215	32.2
Friendly	269	40.2
Socialized	72	10.8
TOTAL:	668	100.0

Source: Compiled from information in Table 5.

Explanation: This summarizes the 668 interactions according to number and percentage of the quality of interaction.

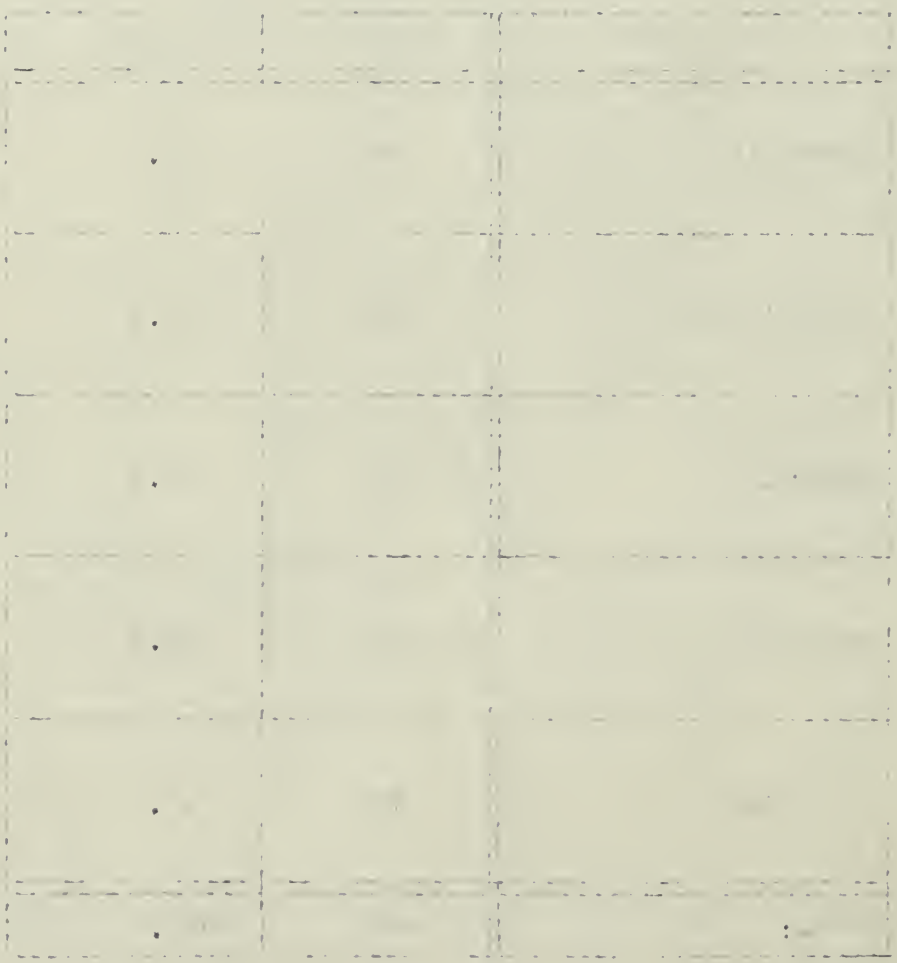


TABLE NO. 7
ANALYSIS RELATIONSHIPS AMONG PEERS

QUALITY OF INTERACTION	57 N-N INTERACTIONS										306 P-P INTERACTIONS									
	QUALITY			TYPE							QUALITY			TYPE						
				68.4% Administrative			31.6% Non-Adm.			Ratio				.7% Administrative			99.3% Non-Adm.			Ratio
	No.	%	No./N	No.	%	No./N	No.	%	No./N	Administistive	Non-Adm.	No.	%	No./P	No.	%	No./P	No.	%	No./P	Administrative	Non-Adm.
AGGRESSIVE	7	12.3	.3	1	2.6	.05	6	33.3	.33	1	6.6	39	12.8	.62	0	0	0	39	12.8	.62	0	.62
AUTHORITARIAN	6	10.5	.33	6	15.4	.33	0	0	0	.33	0	7	2.3	.11	0	0	0	7	2.3	.11	0	.11
NEUTRAL	23	57.8	1.83	29	74.4	1.6	4	22.2	.22	7.3	1	63	20.6	1	1	.5	.01	62	20.4	1	1	10
FRIENDLY	9	15.8	.5	3	7.6	.16	6	33.3	.33	1	2	143	46.7	2.3	1	.5	.01	142	46.7	2.29	1	229
SOCIALIZED	2	3.5	.11	0	0	0	2	11.2	.11	0	.11	54	17.7	.87	0	0	0	54	17.8	.87	0	.87
TOTAL:	57	100	3.1	39	100	2.16	18	100	1	2.16	1	306	100	4.9	2	100	.03	304	100	4.9	1	163.3

Source: Compiled from information in Table 2 and Table 4

Explanation: Distribution is shown for each of 57 nurse-nuree and 306 patient-patient interactions according to type as related to quality, reflecting the number, percentage, and average number per person and an average ratio for each pereon according to the two-fold classification. The quality is summarized for each interrelationship in terms of the total number, percentage, and average for each pereon.

TABLE NO. 8
ANALYSIS OF NURSE - PATIENT RELATIONSHIPS

QUALITY OF INTERACTION	189 N-P INTERACTIONS									116 P-N INTERACTIONS								
	QUALITY			TYPE						QUALITY			TYPE					
				2.3% Administrative			57.7% Non-Adm.			Ratio			7.8% Administrative			92.2% non-Adm.			Ratio	
	No.	%	No./N	No.	%	No./N	No.	%	No./N	Administrative	Non-Adm.	No.	%	No./P	No.	%	No./P	Administrative	Non-Adm.
AGGRESSIVE	4	2.1	.22	1	1.2	.05	3	2.8	.16	1	3.2	L6	13.8	.25	2	22.3	.03	14	13.1	.22	1	7.3
AUTHORITARIAN	33	17.5	1.83	36	32.5	1.4	7	6.4	.38	3.7	1	0	0	0	0	0	0	0	0	0	0	0
NEUTRAL	73	38.6	4.05	42	52.5	2.3	31	28.4	1.72	1.3	1	46	39.6	.74	6	66.7	.09	40	37.4	.64	1	7.1
FRIENDLY	74	39.1	4.11	8	10	.44	66	60.6	3.6	1	8.3	43	37.1	.69	1	11.1	.01	42	39.2	.67	1	67
SOCIALIZED	5	2.7	.27	3	3.8	.16	2	1.8	.11	1.4	1	11	9.5	.17	0	0	0	11	10.3	.17	0	.17
TOTAL:	189	100	10.5	80	100	4.4	109	100	6.5	1	1.3	116	100	1.8	9	100	.14	107	100	1.72	1	12.2

Source: Compiled from information in Table 2 and Table 4

Explanation: This shows the distribution of each of 189 nurse-patient and 116 patient-nurse interactions according to type as related to quality, showing the number, percentage, and average number per person and the average ratio per person according to the two-fold classification. The quality is summarized for each interrelationship in terms of the total number, percentage, and average for each pereon.

TABLE NO. 9

INTERACTIONS OF NURSES AND PATIENTS COMPARED ACCORDING TO QUALITY

QUALITY OF INTERACTION	NURSES AND PATIENTS ORIGINATING								RATIO FOR INTERRELATED INTERACTIONS					
	36.8% Nurses Originating			63.2% Patients Origin.			Ratio		N N : : N P	P P : : N P	N P : : P N	N P : : P P	N P : : N N	N P : : N P
	No.	%	No./N	No.	%	No./P	Nurses	Patient						
AGGRESSIVE	11	4.5	.61	55	13	.88	1	1.2	1.7::1	1::2.4	1::1.1	1::2.8	1.5::1	1::1.6
AUTHORITARIAN	39	15.9	2.1	7	1.7	.11	19	1	1::5.5	0::0.1	1.8::1	16.6::1	0.33::0	3::1
NEUTRAL	106	43.1	5.8	109	25.8	1.75	3.3	1	1::2.2	1::1.2	5.4::1	4::1	2.4::1	1.8::1
FRIENDLY	83	33.7	4.61	186	44.1	3	1.5	1	1::8.2	1::3.3	5.9::1	1.7::1	1::1.3	1::4.6
SOCIALIZED	7	2.8	.38	65	15.4	1.04	1	2.7	1::2.4	1::5.1	1.5::1	1::3.2	1::1.5	1::7.9
TOTAL:	246	100	13.3	422	100	6.8	1.94	1	1::3.3	1::2.7	5.8::1	2.1::1	1.7::1	1::1.5

Source: Compiled from information in Table 7 and Table 8.

Explanation: This shows the distribution of 246 nurse originated and 422 patient originated interactions according to quality, showing the total number, percentage, and average number originated by each person according to the two-fold classification as well as comparing the average ratio of the persons involved. Pathways of interactions are then compared on an average ratio basis according to quality.

Jenkins, E.H.
Interpersonal Relationships in Psychiatric Nursing